DOCUMENT RESUME

ED 152 057 EC 110 120

AUTHOR	Wawrykow, George M.
TITLE	Mental Retardation in Persons Age 35 and Over: A Texas Perspective.
INSTITUTION	Texas State Dept. of Mental Health and Mental Retardation, Austin.
SPONS AGENCY	Texas Research Inst. of Mental Sciences, Houston.
PUB DATE	[76]
NOTE	207p.; Not available in hard copy due to marginal legibility of appendices
EDRS PRICE	MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS	*Community Services; *Demography; Exceptional Child Research; *Mentally Handicapped; Older Adults; State Programs
IDENTIFIERS	*Texas

ABSTRACT

The report examines demographic factors involved and services available for mentally retarded Texans over 35 years old. Prevalence estimates are reviewed, and statistics are given for the number of Texans served in state and community programs. Adaptive behavior level, sex ethnicity and socioeconomic status are among the factors considered in a description of individual characteristics. Among findings listed are that mental retardation appears to decrease slightly in prevalence with age, the largest proportion of services to older mentally retarded persons is provided by the state schools, and the primary destination on discharge for older age groups of mentally retarded persons is the nursing home. Recommendations are made for service, education, and research. The bulk of the document is composed of tables with demographic data and 11 appendixes. (CL)

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MENTAL RETARDATION IN PERSONS AGE 35 AND OVER

A TEXAS PERSPECTIVE

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ACKNOWLEDGMENTS

The author is grateful to the sponsoring institution, the Texas Research Institute of Mental Sciences, and especially to Dr. Charles M. Gaitz, Director of Gerontological Research, who with Welton (Buddy) Calvert, Research Specialist, saw the need for this investigation. Their assistance together with that of Judith Scott and Rosemary McCaslin, both from the gerontological research of TRIMS, were invaluable in helping to organize and edit the final copy. Buddy Calvert gave additional help by providing contacts with personnel throughout TDMHMR, other state agencies and the private sector.

Deepest appreciation is also due Dr. Dan Sheehan, Director of TDMHMR, program support services, Dr. Franklin, Chief of TDMHMR, programanalysis and statistical research, and Mark Mason, Senior Statistician, and their staff for the patience and cooperativeness in extracting the copious data for the tables. Thanks are also extended to Marcia McCrary Tibbets, Jo McKinnon, and Jan LaRose for typing, to Les Goekler of the TRIMS library for locating manuscripts, to Lillie Mae Phillips and Juanita Edwards for duplicating the manuscript.

To the state school superintendents, MHMR executive directors and their staffs, thanks are given not only for the grass roots perspective that they offered, but also for their warm, cooperative, and open spirit that made this investigation enjoyable.

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INTRODUCTION

Less than half a century ago, the mentally retarded person was regarded as a child for the duration of his life. Time and development seemed to be held in abeyence from the time a retarded person reached school age until his death - be it six years or sixty (Dayton, 1922). Gradually, however, with the development of programs in state schools, an extended adolescent lifestyle became a part of the retarded person's development (Davies, 1958). During the 1970's, there has been an interest in helping the retarded person live in a normalized developmental sequence which includes young adulthood in addition to childhood and adolescence (Siegelman, 1973). Only very recently has the service community been interested in facilitating a productive middle age (Juliana, 1975; Presidents Commission on Mental Retardation, 1968) or a dignified old age for the mentally retarded (Dickerson, et al., 1974; Hamilton and Segal, 1975; Kriger, 1975, Talkington and Chiovaro, 1969). Most research and training efforts in mental retardation have focused on children and adolescents with progressively decreasing study on older populations (Ellis, 1968-1976). Integration of the information gathered through personal interviews with personnel in Texas state schools and literature reviews (Dickerson, et al., 1974; Kriger, 1975; Segal, 1976) suggests that programming often becomes least appropriate after age 35, and, indeed, that by age 35 the mentally retarded person may be equivalent to a 65 year old or older in many ways. To help fill some of the gaps in available information this study concerns itself with retarded persons age 35 and older.

The report has been organized into six parts. In the first section, the prevalence of mental retardation in Texas has been estimated for middle age and elderly retarded persons. In the second part, residential and community services in the state of Texas are explored. Next, available demographic data on retarded persons 35 and over in TDMHMR schools, hospitals, and community programs are presented. Included is information on the adaptive behavior level (ABL), sex, ethnicity, socioeconomic status, psychological difficulties, physical impairment, convulsive disorders, referral source and discharge destination of these clients. The fourth section comments on the community lifestyle of discharged persons. Next, pertinent points are summarized and, lastly, a series of conclusions and recommendations are presented and discussed. Primary data and other supporting information are presented in several appendices so that a reader is free to pursue points of particular interest.

OBJECTIVES OF THE STUDY

1. To explore the demographics of mental retardation among aging Texans and the current objectives in facilities and programs to serve them.
2. To integrate the findings in order to recommend directions in service, research, and education to better meet the needs of middle aged (35-54) and elderly (over age 55) mentally retarded persons in Texas.

METHODOLOGY

Statistical data on the mentally retarded population in Texas was gathered through computer runs from TDMHMR data banks and library searches utilizing the resources of several libraries. Literature searches were conducted through the Governor's Committee on Aging, Medline, Psychological Abstracts and Social Science Review. Several leaders in the fields of aging or mental retardation were interviewed by telephone and impressionistic data (appendix H) were gathered by site visits to six state schools, three human development centers, four community MHMR centers and local contract facilities (appendix B).

DATA

A. PREVALENCE

Prevalence estimates for the adult mentally retarded vary: 0.125% (Tarjan, 1970, 1% (Craig, 1974), 2.0% (California, 1965), 2.7% (Craig, 1976), 2.76% for persons age 35-54 and 2/3% for persons 55-69 (Conley, 1973). Since Conley's figures represent a compilation of the efforts of many different investigators, his rates were chosen for use in this paper. The pattern of decreasing prevalence of mental retardation with aging may be due to high mortality rates of mentally retarded persons (Conley, 1973; Miller, Sabagh and Dingman, 1962) and intergration of persons into the general population as they acquire social skills (Mercer, 1970; Tarjan, 1970).

Conley's estimates of the prevalence of mental retardation applied to the population figures for Texas suggest that there may be as many as 73,836 mentally retarded persons age 35-54, and 47,849 mentally retarded persons age 55 and older in the state (table 1). Thus, one may estimate a total of 121,685 mentally retarded persons age 35 or older in Texas.

B. SERVICES TO THE MENTALLY RETARDED

Only 6,236 mentally retarded persons age 35 and older were served through programs receiving funding from the Department of Mental Health and Mental Retardation in FY 1975: two thirds, in state schools (n = 3,892); one sixth, in state hospitals (n = 1,228); and one sixth, in community programs (n = 1,115) (tables 2 and 3). These numbers represent only five percent of the estimated population of 121,685 mentally retarded persons age 35 and over.

Sheehan & Craft (1975) report that state agencies other than TDMHMR (e.g., Department of Corrections and the Department of Public Welfare) have a number of mentally retarded clients. Many of these persons, however, are among those listed as receiving services from TDMHMR facilities and the extent of overlap is not known at this time.

Only a handful of private residential agencies are serving adult retarded persons in Texas (Sheehan and Craft, 1975). The two largest include the Harris County Center for the Retarded - Cullen Hall, and the Marbridge Foundation Facilities, located in several Texas communities. Many residents of these private facilities are also served by TDMHMR.

1. TDMHMR - Schools and Hospitals

Mentally retarded Texans are primarily served in the state schools where 14,355 persons were served in FY 1975; 73 percent of these residents were aged 0-34, 18 percent were aged 35-54, and only 9 percent were aged 55 and older (table 2). In the same year, state mental hospitals served 2,612 mentally retarded persons, 53 percent of whom were aged 0-34, 30 percent aged 35-54, and only 17 percent aged 55 and older. These percentages illustrate the fact that both state hospitals and state schools serve primarily younger persons among the mentally retarded population.

During FY 1975 a reduction in the numbers of institutionalized persons resulted from discharges exceeding admissions (table 2). As indicated in the following table, the smallest proportion of those served who were discharged were in the 35-54 age group, followed by the 55 and older age group. At the same time it is evident from this table that the ratio of admissions to discharges was greatest for the 0-34 age group and decreased with age.

	Schools			Hospitals		
	0-34	34-54	55+	0-34	35-54	55+
Discharges/Served	.11	.06	.11	.64	.49	.51
Admissions/Discharges	.83	.49	.12	.91	.65	.31

Little data was available from the TDMHMR data banks on programs for retarded in state schools or hospitals, and limited program information was available on community programs (TDMHMR Data Book B, 1975).

Of the facilities visited, only two, San Angelo and Travis State School, had age-specific programs for elderly mentally retarded persons. Both schools have substantial numbers of residents age 35 and over. Programs specifically for these age groups may exist in the facilities not visited, but inquiry did not substantiate their existence. Middle aged and elderly persons, however, are included in the ongoing programs of most facilities.

2. Community Programs with TDMHMR Funding

Less than 1 percent (n = 1,115) of the estimated 121,685 mentally retarded persons age 35 and older were served through community programs receiving TDMHMR funding in FY 1975 (Table 3). About 4,197 mentally retarded persons over age 21 were served in 1975. Of these, 73 percent were aged 21-34 (n = 3,082); 22 percent, aged 35-54 (n = 918); less than 4 percent, aged 55-64 (n = 158); and less than 1 percent, aged 65 and older (n = 39). These percentages indicate that services at the community level decline dramatically with age. If the small numbers of mentally retarded persons age 35 and older who were served were averaged among the 27 community MHMR centers, 8 state hospital and 12 state school outpatient/outreach departments, 4 human development centers, and TRIMS, then the average number of middle-aged and older persons served in FY 1975 in each of these facilities would be 10.5, age 35-54; only 2, age 55-64; and less than 1, age 65 and older.

C. CHARACTERISTICS OF MENTALLY RETARDED PERSONS SERVED

Most investigation of mental retardation have been with children, adolescents and young adults. Few studies were uncovered concerning middle age and fewer still concerning elderly mentally retarded persons. One reason for this may be the impression that demographic data on the populations is lacking. TDMHMR data banks, however, were found to contain a wealth of information on mentally retarded persons age 35 and over who are served by state facilities.

1. Adaptive Behavior Level

Between the age groups, there are differences in the adaptive behavior levels (ABL) of residents (Table 4 and appendices C and D). Since different programs are appropriate at each ABL, programs must necessarily vary with age to accommodate the changing ABL factor.

Figure 1 shows that among the children served severe levels of retardation predominate; almost half of those served were profoundly retarded while less than 5 percent were mildly retarded. Among the adolescents, while the predominance of severe levels of retardation continues, the proportion who are profoundly retarded drops to one third of those served and there are increases in the proportions of less severely retarded persons served. By early adulthood there is a shift to higher proportions of moderate and severely retarded persons being served with further reductions in the profoundly retarded category. Within the elderly group, no mildly retarded persons are served and the proportion of moderately retarded persons served drops to 6 percent. At the same time the proportion of severely retarded persons served increases until by age 75 this group comprised almost 60 percent of those served. Eighty-two percent of these oldest residents are either severely or profoundly retarded.

2. Sex

There is a steady decrease in the proportion of male to female mentally retarded persons served in state schools and community programs (Tables 5 and 6) from about 60 percent (age 0 to 34) to about 44 percent (age 55 and over). This pattern follows the expectation that males have lower survival rates than females (Madigan and Vance, 1957). In the state hospitals, however, the proportion of males remains constant at 60 percent regardless of age. Speculations on the reasons that older retarded males are more likely than females to be placed in state mental hospitals might include: (a) increase in psychiatric disturbance and manifestations of unacceptable behavior due to a higher incidence of organic brain syndrome in males than females; (b) lack of homemaking skills leading to increased dependence, lessened responsibility, and more time for "self interest" or "idle" behavior that is labeled deviant.

3. Ethnicity

Within the small groups of older retarded persons served, the proportion of whites increases and the proportion of minorities decreases with increasing age (tables 5 and 6). For age groups 0-34, 35-54, and 55 and older: (1) the proportions of Spanish surnamed persons are, (a) schools -- 17%, 10% and 5%, (b) community -- 22%, 15% and 9%, (c) hospitals -- 16%, 14% and 13%; (2) the proportions of blacks are: (a) schools -- 9%, 7% and 5%, (b) community -- 24%, 14% and 15%, (c) hospitals -- 25%, 23% and 12%. The hypothesis that decreasing proportions of minorities may be due to a lower survival rate for minorities than for whites needs to be investigated.

4. Socioeconomic Status

Data was not available on the socioeconomic status (SES) of the families of the mentally retarded persons served. National data indicates that mental retardation is thirteen times more prevalent in lower than in middle or upper SES families and is most prevalent in non-white, low SES families (Conley, 1973). In one study, the prevalence rate of mental retardation in this latter group was 42.9 percent (Heber, Denver and Conry, 1960).

5. Psychological Difficulties

Psychological impairment for mentally retarded persons within state schools appears to decrease with age (Table 7). The overall proportion is 10%; in the three age groups of 0-34, 35-54, and 55 and older, the proportions are 11%, 9% and 7%, respectively.

Of those state school residents with reported psychological difficulties, 15 percent have been diagnosed as psychotic, 5 percent as neurotic, 45 percent as character disorders and 28 percent as unspecified diagnosis (Table 7).

Approximately 30 percent of mentally retarded patients in state hospitals have a primary diagnosis of psychosis and 8 percent have a primary diagnosis of neurosis or character disorder (Table 8 and 9). This is markedly lower than national statistics where, across all age levels, severe emotional handicaps have been reported in over 35 percent of the population (Conroy and Derr, 1971).

6. Physical Diagnoses, Sensory and Mobility Impairment

Among mentally retarded residents of state schools, the most common physical disorders involve the nervous system (about 30% for each of the age groups), the circulatory system (1% for ages 0-34, 6% for ages 35-54, and 19% for ages 55 and over), the endocrine-metabolic system (less than 5% for each of the age groups), and congenital anomalies (9%, 5% and 3% respectively) (Table 10).

Among hospital and state school residents, visual impairment increases with age to a maximum of 38% in the oldest age group. Hearing impairment ranges from 4% in the 0-34 age group in state hospitals to 19% in the 55 and older age group in state schools (Table 11). These compare with national averages of 25% with visual impairment and 15% with hearing impairment for all ages.

In Texas, multiple sensory impairment was diagnosed in 5 percent of state school residents aged 35 to 44 and 13 percent of those aged 55 and older (Table 12). Mobility impairment is reported for 32 percent of the middle aged and 40 percent of the older age group. Motor dysfunction was reported in 52 percent of the 0-34 age group, 39 percent of the 35-54 age group, and 38 percent of the 55 and older age group (Table 13). The comparative national average for all age groups is 42 percent (Conroy and Derr, 1971).

7. Convulsive Disorders

Convulsive disorders of all types are diagnosed in almost 40 percent of mentally retarded persons in state schools, but in less than 30 percent of those age 35 and over (Table 14). Both of these percentages are considerably higher than the national average of 18 percent (Conroy and Derr, 1971).

8. Referral Source

Referrals of middle-aged and elderly retarded persons to state schools occur in about equal numbers from primary caretakers, other TDMHMR institutions, and community MHMR centers. The primary sources of referrals to state hospitals, however, are the courts and law enforcement agencies (Table 15). In sharp contrast, referrals to community programs are primarily from self, family, and friends (Table 16).

SUMMARY

CONCLUSIONS AND RECOMMENDATIONS

9. Disposition on Discharge

The reported primary destination on discharge from schools or hospitals for persons age 55 and older is a nursing home (Table 17). Less frequent discharge distinations from both systems for older clients are self, family or friends, community MHMR centers, and hospital outreach services. Among the middle age group there are approximately the same numbers discharged to each of these four destinations from the hospitals. The predominant destination for the 35-54 age group discharged from state schools is self, family or friends (Table 17).

D. COMMUNITY LIFESTYLE OF DISCHARGED PERSONS

TDMHMR contracted with the Research and Training Center at Texas Tech University to assess the lifestyles of retarded persons discharged and/or furloughed from the state schools from 1968 through 1973. To date, the discharge data has been analyzed to show the differences in lifestyles between retarded persons above and below an I.Q. level of 55 (Bell, 1976) and to give a profile of the leisure activities of these groups (Bell and Shoenrock, 1976). Only one other investigation was found that focused on post-discharge lifestyle of older retarded persons (Kriger, 1975). The study revealed that, while basic needs of these discharged older persons were being met, they were isolated in their community setting and did not take part in community activities.

SUMMARY

The following statements summarize the data which has been included in this report.

1. The prevalence of mental retardation tends to decrease slightly with age.

2. Only five percent of the estimated population of mentally retarded persons receive TDMHMR services; services decrease with age and are practically nonexistent for the elderly.

3. The largest proportion of services to older mentally retarded persons is provided by the state schools.

4. The lack of adequate services for elderly mentally retarded persons is especially evident in community programs - MHMR centers, activity centers or sheltered workshops - and in the lack of alternative living situations in the community (other than with relatives or in nursing homes).

5. There is little evidence that substantial numbers of older mentally retarded persons are served by state facilities other than TDMHMR or by private agencies.

6. The mix of adaptive behavior level (ABL) varies with age.

7. Although there are fewer older men in the population, older mentally retarded men are over-represented in state hospitals compared to women.

8. According to studies, diagnosis of mental retardation is most prevalent in non-white, low socio-exonomic status groups. Lack of SES data available for this study does not allow a thorough analysis of prevalevance figures for the state of Texas.

9. Although national figures show that mentally retarded persons at all ages have a high incidence of mental illness, Texas data indicate a decrease in diagnosis of these problems with age.

10. Although mentally retarded persons at all ages levels have a high incidence of physically handicapping conditions, many of these handicaps increase in the older age groups.

11. The primary destination on discharge for older age groups of mentally retarded persons is the nursing home.

12. Other investigators have found that the home is the primary focus of activity for the older mentally retarded persons, that community participation is minimal, and that discharge to the community is usually synonomous with discharge to isolation.

CONCLUSIONS AND RECOMMENDATIONS

A major need of mentally retarded persons age 35 or older in Texas is increased service. To provide the necessary quality and quantity of services, both entrance level and continuing education within TDMHMR would need to be geared toward serving this population. To ensure the effectiveness of educational programs for staff as well as service and training for clients, both basic and applied research must be ongoing.

SERVICE

Disproportionately small numbers of the estimated population of mentally retarded persons age 35 or older are receiving services. Because older mentally retarded persons may no longer have family advocates to speak for them and may have limited ability to speak for themselves, there is little insistence for services to meet their special needs. In addition, the fact that the mentally retarded person is served by three sets of personnel within TDMHMR (state school residential staff, institutional community placement staff, and the community center staff) increases the likelihood of fragmented services.

It is recommended:

1. ADVOCACY: That a state program be instituted that has a spokesperson to specifically speak to the issues, concerns and special needs of mentally retarded persons age 35 and older.

    a. That this spokesperson increase public awareness and understanding of the needs and rights of older mentally retarded persons as well as their special problems.

    b. That this spokesperson seek to increase services that are developmentally and age appropriate for the middle age and elderly.

    c That this spokesperson work with and through information and referral services that are currently in operation.

    d. That this spokesperson seek to help others institute programs that yield as normalized a set of experiences for each middle age and elderly retarded individual as possible in view of personal handicaps so s/he realizes full citizenship and legal rights.

   e. That this spokesperson promote programs designed to provide service to middle-aged and elderly retarded persons in the least restrictive manner to ensure growth, a sense of independence, responsibility and enhanced feelings of self worth.

   f. That the spokesperson be consulted regarding any additions or renovations to existing or contemplated physical plants.

2. QUANTITY OF COMMUNITY SERVICES: That rapid expansion of services to meet the special needs of middle aged and elderly mentally retarded persons be concentrated primarily in the community MHMR centers.

   a. That a coordinator be designated in each center to facilitate use of ongoing programs in the community by middle age and elderly mentally retarded persons.

   b. That special programs designed to meet the unique needs of mentally retarded persons age 35 or over be instituted [e.g. avocational training for leisure activities during retirement or placement in a regular work setting under a master trainer employed by TDMHMR (Appendix H.; ENCORE, Nebraska, 1976)].

   c. That a full range of community living alternatives for middle aged and elderly mentally retarded persons be developed jointly by state schools and local MHMR centers (Appendix H; Sigelman, 1973).

   d. That transportation services be developed to enable middle aged and elderly retarded persons to participate in community programs.

3. QUALITY OF SERVICE: That the quality of services and facilities for middle aged and elderly retarded persons be maintained at JCAH and/or ICF-MR standards and that accreditation be sought for all facilities.

   a. That the institutions be changed from long term, high capacity, self contained facilities to facilities for specialized treatment and habilitation.

   b. That client training programs be instituted that are developmental-stage specific (age ABL).

   c. That each client be afforded a sequential training program, progressing from basic human skills to educational skills to vocational skills, and that avocational skill training be an integral part of the program at all levels.

4. COORDINATION AMONG SERVICE PROVIDERS: That integration of all services by TDMHMR with those of community MHMR centers be made a high priority at all levels: individually, regionally, and statewide.

   a. That formal administrative linkage be established and empowered to achieve this coordination.

   b. That activities and services provided by state facilities or community centers be made available to the defined population of either.

   c. That continuity of service be assured for persons furloughed and discharged from the schools and hospitals to the community.

EDUCATION

While psychology, social work, nursing and special education curricula may better equip staff to work effectively with young and adolescent retarded persons, no comparable curricula have been available regarding middle age or elderly retarded persons. Consequently both entrance level and continuing education of staff is needed in order to ensure that training programs meet the special needs of these retarded groups. Such staff education must be accompanied by efforts to increase public understanding of the needs, rights, and capabilities of the retarded, and public acceptance of responsibility for habilitation of these persons. It is recommended:

1. ENTRANCE LEVEL EDUCATIONAL REQUIREMENTS: That an innovative associate degree program be developed based on knowledge of the fields of gerontology and mental retardation.

   a. That such a program include both classroom and field experiences.

   b. That the Gerontology unit at TRIMS, the Research and Training Center at Texas Tech University and the Center for Studies in Aging at North Texas State University be utilized for these experiences.

2. CONTINUING EDUCATION: That an intensive ongoing program be instituted both regionally and statewide to further educate the staff concerning the needs, rights, and capabilities of the middle aged and elderly retarded.

a. That such programs be offered on a regional basis with conjoint participation of state schools, hospitals and MHMR centers.

b. That the state spokesperson serve a clearinghouse function to identify expertise available in Texas for older mentally retarded persons and to promote the use of that expertise for continuing education throughout the state.

3. PUBLIC EDUCATION: That a statewide program of public education concerning the middle aged and elderly retarded persons be developed by TDMHMR.

    a. That this program utilize all facets of communication media including radio, television, and newspapers.

    b. That this program be designed to (1) educate the public about the needs, rights and capabilities of middle aged and elderly retarded persons and (2) inform families of this target group about available services and programs.

RESEARCH

Extensive review of the literature indicates that relatively little basic or applied research exists or is currently being conducted that addresses the problems of middle aged and elderly retarded persons. One of the problems encountered during the present investigation was the inability to collect appropriate program data on this population. This trend must be reversed if meaningful programs are to be designed to meet the needs of retarded persons above the age of 35. It is recommended:

1. DATA USE: That data generated within TDMHMR be available in a form that facilitates maximum use for program planning and evaluation.

    a. That changes be made in the TDMHMR data system to enable information retrieval of the following:

        (1) group profile data

        (2) direct service data specifically on middle aged and elderly mentally retarded persons

        (3) post discharge living arrangement (as distinct from discharge service referral data).

b. That the initial data collection effort represented by this report be disseminated to persons interested in the mentally retarded age 35 or older.

    (1) that the report be distributed to TDMHMR facilities and community MHMR centers throughout Texas.

    (2) that this report be edited into a monograph form appropriate for distribution to interested persons outside Texas.

    (3) that an oral presentation of this report be given at appropriate conferences and meetings (eg. 1977 conference on "The Elderly Mentally Retarded in Texas" to be held prior to TRIMS Fourth Annual Gerontology Forum, the 1977 Annual Meeting of the Gerontological Society, and the 1977 Annual Meeting of the American Association on Mental Deficiency.

c. That resources be made available to the Research and Training Center at Texas Tech University for multilinear regression analysis (Ward and Jennings, 1974) of the data regarding the lifestyle of discharged persons in order to determine which constellation of demographic and program variables best predict successful community placement (Appendix E).

2. PREVALENCE STUDY: That a well designed and adequately funded study be undertaken to determine the accuracy of current estimates of the number of mentally retarded persons in Texas.

    a. that, in addition to age and demographic data, care be taken to control for other factors which appear to be important such as ethnicity, urbanicity, and regional differences.

    b. that the ability of TDMHMR to meet the demand for services created by the investigative procedures be taken into account in planning the study.

3. SURVIVAL RATES: That curves be constructed reflecting the differential rate of survival by sex, ethnicity, and adaptive behavior level of retarded persons in the state school system of Texas.

4. NORMALIZATION: That a research and development program be implemented to compare the relative effectiveness of community and institutional placement for middle aged and elderly retarded persons; that this take into account the effectiveness of the programs, success of the various living arrangements, success of lifestyles and cost effectiveness (Appendix K).

TABLES

Demographic Data in Tabular Form

TABLE 1

Estimated Numbers of Mentally Retarded Persons in Texas by ABL, IQ, and Age Group

LEVEL	IQ	AGE 35-54		AGE 55+		TOTALS
		%	Est. No.	%	Est. No.	
PROFOUND	0-24	.09	2,408	.05	1,040	3,448
SEVERE/MODERATE	25-49	.22	5,885	.15	3,121	9,006
MORE SEVERE	0-49 Total	.31	8,293	.20	4,161	12,454
MILD	50-69	2.45	65,542	2.1	43,688	109,230
ALL LEVELS	Total 0-69	2.76	73,836	2.3	47,849	121,685

Estimated numbers based on population estimates in FY 1975 of 4,755,700 age 35+, 2,675,200 age 35-54, 2,080,400 age 55+.

FY 1975

TABLE 2

Mental Retardates[a] Movement
Texas State Hospitals and Schools by Age

		STATE HOSPITALS				STATE SCHOOLS			
		AGE							
		0-34	35-54	55+	TOTAL	0-34	35-54	55+	TOTAL
ADMISSIONS	DIRECT	600	175	44	819	793	39	7	839
	TRANSFERS IN	202	78	58	338	152	34	11	197
	TOTAL	802	253	102	1157	945	73	18	1036
DISCHARGES	DIRECT	678	284	155	1117	834	75	66	975
	TRANSFERS OUT	211	105	66	382	282	74	77	433
	TOTAL	889	389	221	1499	1116	149	143	1408
	IN RESIDENCE AT END OF FISCAL YEAR	440	378	195	1013	8189	2297	1132	11618
	BOOK POPULATION AT END OF YEAR	483	414	209	1106	9349	2526	1222	13097
	TOTAL POPULATION SERVED DURING YEAR	1384	795	433	2612	10462	2634	1259	14355

a. Primary, secondary, tertiary diagnosis

FY 1975

TABLE 3

Prevalence Mental Retardates[a] Served
Texas Community Programs by Age Groups

AGE GROUPS		COMMUNITY MHMR CENTERS	HOSPITAL OUTPATIENT OUTREACH CLINIC	SCHOOL OUTPATIENT OUTREACH SERVICES	CENTERS FOR HUMAN DEVELOPMENT	CONTRACT FACILITIES	TOTAL	
CHILDREN	0-12	3116	83	612	238	9		4058
ADOLESCENTS	13-20	2507	128	340	195	6		3176
YOUNG ADULTS	21-34	2942	307	644	248	17	4158	3082
MIDDLE AGE	35-54							918
ELDERLY	55-64							158
	65+	17	13	8	1	0		39
TOTAL		8582	531	1604	682	32		11431

a. Primary, secondary, or tertiary diagnosis

FY 1975

TABLE 4

Prevalence Mental Retardates[a] Served
Texas State Hospitals and Schools
Age Group by Adaptive Behavioral Level

	STATE HOSPITALS			STATE SCHOOLS		
	AGE GROUP					
ADAPTIVE BEHAVIOR LEVEL	0-34	35-54	55+	0-34	35-54	55+
NO RETARDATION				40	16	12
BORDERLINE	397	128	47	185	21	13
MILD	435	234	102	1127	208	91
MODERATE	280	207	126	1932	619	274
SEVERE	101	127	81	3204	1092	589
PROFOUND	79	50	32	3599	653	265
UNSPECIFIED	92	49	45	375	27	15
TOTAL	1384	795	433	10462	2634	1259

a. Primary, secondary, tertiary diagnosis

FY 1975

TABLE 5

Prevalence Mental Retardate[a] Residents/Book Population[b]
Texas State Hospitals and Schools by Sex, Ethnicity and Age Group

		State Hospitals			State Schools		
	AGE	0-34	35-54	55+	0-34	35-54	55+
SEX	MALE	264	230	116	5351	1301	535
	FEMALE	176	148	79	3998	1225	687
ETHNICITY	WHITE	258	237	146	6147	2092	1096
	SPANISH SURNAME	72	54	25	1625	260	60
	BLACK	110	87	23	854	168	65
	OTHER	0	0	1	23	6	1
	TOTAL	440	378	195	9349	2526	1222

a. Primary, secondary, tertiary diagnosis

b. State school figure, book population. Includes residents and persons on furlough

FY 1975

TABLE 6

Prevalence Mental Retardates[a] Served
Texas Community Programs, Sex, Ethnicity, Income by Age Groups

AGE	0-34	35-54	55-64	65+	TOTAL
SEX GROUPS SERVED					
MALES		464	88		6518
FEMALES		454	109		4913
ETHNIC GROUPS SERVED					
ANGLO		619	139		5976
SPANISH SURNAME		152	17		2439
BLACK		132	37		2670
OTHER		6	0		58
UNKNOWN		9	4		288
INCOME LEVELS SERVED					
UNDER $50 (WEEKLY)		442	120		2841
$50-99		154	15		1979
$100-149		53	5		1383
$150-199		10	4		799
$200-299		13	2		760
$300/ABOVE		13	1		493
UNKNOWN/NOT REPORTED		233	50		3176
TOTAL CLIENTS SERVED	10316	918	158	39	11431

a. Primary, secondary or tertiary diagnosis

FY 1975

TABLE 7

PREVALENCE MENTAL RETARDATES[a] BOOK POPULATION TEXAS STATE SCHOOLS BY PSYCHIATRIC IMPAIRMENT[b]

PSYCHIATRIC IMPAIRMENT	AGE			
	0-34	35-54	55+	TOTAL
PSYCHOSIS	141	38	13	192
NEUROSIS	38	24	5	67
CHARACTER	468	89	25	582
PSYCHOGENIC	6	0	0	6
OTHER	85	7	1	93
UNSPECIFIED	254	69	42	365
TOTAL	992	227	86	1305
NONE	8182	2252	1106	11540
NOT REPORTED	175	47	30	252
GRAND TOTAL	9349	2526	1222	13097

a. Primary diagnosis
b. Secondary diagnosis

FY 1975

TABLE 8

Prevalence Mental Retardates^a Residents
Texas State Hospitals by Primary Psychiatric Diagnosis by Age Group

DIAGNOSIS	AGE 0-34	35-54	55+	TOTAL
SCHIZOPHRENIA	77	84	46	207
OTHER FUNCTIONAL PSYCHOSES	4	3	0	7
PSYCHOTIC OBS	39	29	17	85
NON-PSYCHOTIC OBS	18	24	17	59
NEUROSIS	2	0	1	3
ALCHOLISM	1	3	3	7
DRUG ABUSE	6	1	0	7
PERS., TRANS., BEHAV., ETC.	35	9	2	46
MENTAL RETARDATION	256	225	108	589
NONE	1	0	0	1
NOT REPORTED	1	0	1	2
TOTAL	440	378	195	1013

a. Primary, secondary, tertiary diagnosis

FY 1975

TABLE 9

Prevalence Mental Retardates[a] Direct Admissions Texas State Hospitals by Alcoholism and Drug Abuse by Age Group

	IMPAIRMENT	AGE			
		0-34	35-54	55+	TOTAL
ALCOHOLISM	EPISODIC EXCESSIVE DRINKING	2	3	0	5
	HABITUAL EXCESSIVE	1	3	0	4
	ALCOHOL ADDICTION	7	15	3	25
	ALCOHOLIC PSYCHOSIS	0	0	1	1
	NON-PSYCHOTIC OBS WITH ALCOHOL	0	0	0	0
	OTHER, UNSPECIFIED	0	0	0	0
	TOTAL	10	21	4	35
	PERCENT OF DIRECT ADMISSIONS	1.67	12.0	9.09	4.27
DRUG DEPENDENCE	HARD NARCOTICS	0	0	0	0
	BARBITURATES, MINOR TRANQUILIZERS, ETC.	1	0	1	2
	AMPHETAMINES AND OTHER STIMULANTS	2	0	0	2
	HALLUCINOGENS	0	0	0	0
	HASHISH, MARIJUANA	1	0	0	1
	PSYCHOTIC OBS WITH DRUG INTOX.	2	0	0	2
	NON-PSYCHOTIC OBS WITH DRUG INTOX.	1	0	0	1
	OTHER, UNSPECIFIED	5	0	0	5
	TOTAL	12	0	1	13
	PERCENT OF DIRECT ADMISSIONS	2.0	0	2.27	1.59

a. Primary, secondary or tertiary diagnosis.

FY 1975

TABLE 10

Prevalence Mental Retardates[a] Residents/Book Population[b]
Texas State Hospitals and Schools by Physical Diagnosis and Age Groups

PHYSICAL DIAGNOSIS (ICDA)	STATE HOSPITALS			STATE SCHOOLS		
	AGE					
	0-34	35-54	55+	0-34	35-54	55+
INFECTIVE PARASITIC	4	5	4	71	43	16
NEOPLASMS	2	2	2	9	11	11
ENDOCRINE, METABOLIC	30	39	20	238	112	63
BLOOD, BLOOD FMG ORG	1	0	0	13	9	0
NERVOUS SYSTEM	64	61	22	2663	722	360
CIRCULATORY	3	28	44	81	151	228
RESPIRATORY	0	0	0	10	1	0
DIGESTIVE	15	13	12	45	57	38
GENITOURINARY	3	6	4	47	25	16
SKIN, SUBCUTANEOUS	16	14	6	79	32	19
MUSCULOSKELETAL	1	2	0	3	10	12
CONGENITAL ANOMALY	10	13	2	836	130	37
OTHER	27	32	18	220	101	69
ILL DEFINED, NONE	255	159	58	3791	806	226
NOT REPORTED	9	4	3	1243	316	127
TOTAL	440	378	195	9349	2526	1222

a. Primary, secondary, tertiary diagnosis

b. State school figure book population includes residents and persons on furlough

FY 1975

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TABLE 11

Prevalence Mental Retardates[a] Residents/Book Population[b] Texas State Hospitals and Schools by Sensory & Mobility Impairment & Age Groups

	STATE HOSPITALS			STATE SCHOOLS		
	AGE					
	0-34	35-54	55+	0-34	35-54	55+
VISUAL IMPAIRMENT						
MILD	47	49	43	1134	360	276
MODERATE	11	21	11	704	163	120
SEVERE	10	7	9	662	89	68
TOTAL IMPAIRED	68	77	63	2500	612	464
PERCENT OF RESIDENTS	15.45	20.37	32.31	26.74	24.23	37.97
HEARING IMPAIRMENTS						
MILD	8	21	30	364	113	128
MODERATE	2	9	2	230	51	58
SEVERE	7	7	6	308	70	46
TOTAL IMPAIRED	17	37	38	902	234	232
PERCENT OF RESIDENTS	3.86	9.79	19.49	9.64	9.26	18.99
MOBILITY IMPAIRMENT						
MILD	30	58	30	1341	414	311
MODERATE	8	14	10	794	156	86
SEVERE	5	5	6	1035	161	66
BEDFAST	1	2	1	870	71	25
TOTAL IMPAIRED	44	79	47	4040	802	488
PERCENT OF RESIDENTS	10.0	20.89	24.10	43.21	31.75	39.93

a. Primary, secondary, tertiary diagnosis

b. State school figures -- book population includes residents and persons on furlough

FY 1975

TABLE 12

Prevalence Mental Retardate Residents[a]/Book Population[b]
Texas State Hospitals and Schools by Multiple Sensory Impairment and Age Groups

DEGREE OF IMPAIRMENT		STATE HOSPITALS			STATE SCHOOLS		
		AGE					
VISION	HEARING	0-34	35-54	55+	0-34	35-54	55+
MILD	MILD	4	11	13	122	51	62
MILD	MODERATE	0	2	1	31	14	12
MILD	SEVERE	1	1	2	25	2	11
MODERATE	MILD	0	4	3	47	9	15
MODERATE	MODERATE	1	2	1	62	13	15
MODERATE	SEVERE	1	1	0	24	13	9
SEVERE	MILD	1	0	3	51	6	11
SEVERE	MODERATE	1	0	0	54	5	13
SEVERE	SEVERE	1	2	2	90	13	11
TOTAL		10	23	25	496	126	159
PERCENT OF RESIDENTS		2.27	6.08	12.82	5.30	4.99	13.01

a. Primary, secondary, tertiary diagnosis
b. State school figure - book population includes residents and persons on furlough

FY 1975

TABLE 13

Mental Retardates[a] Book Population
Texas State Schools by Motor Dysfunction

MOTOR DYSFUNCTION	AGE			
	0-34	35-54	55+	TOTAL
ATAXIA	271	102	31	404
HYPOTONIA	324	98	37	459
CHOREOATHETOSIS	88	6	4	98
DYSTONIA	67	9	7	83
RIGIDITY	79	17	6	102
TREMORS	34	24	16	74
SPASTICITY	2153	302	84	2539
OTHER	269	26	9	304
UNSPECIFIED	1532	401	275	2208
TOTAL	4817	985	469	6271
NONE	4410	1503	733	6646
NOT REPORTED	122	38	20	180
GRAND TOTAL	9349	2526	1222	13097

a. Primary, secondary or tertiary

FY 1975

TABLE 14

Mental Retardates[a] Book Population
Texas State Schools by Convulsive Disorder

CONVULSIVE DISORDER	AGE			
	0-34	35-54	55+	TOTAL
AKINETIC	18	2	1	21
AUTONOMIC	11	18	4	33
FOCAL	20	1	2	23
MAJOR MOTOR	2261	474	241	2976
MYOCLONIC	73	0	0	73
PETIT MAL	130	21	15	166
PSYCHOMOTOR	49	4	0	53
OTHER	228	10	3	241
UNSPECIFIED	952	186	60	1198
TOTAL	3742	716	326	4784
NONE	5490	1773	876	8139
NOT REPORTED	117	37	20	174
GRAND TOTAL	9349	2526	1222	13097

a. Primary, secondary or tertiary diagnosis

FY 1975

TABLE 15

Prevalence Mental Retardates[a] Direct Admissions Texas State Hospitals and Schools by Contact Source

	STATE HOSPITALS			STATE SCHOOLS		
	AGE					
	0-34	35-54	55+	0-34	35-54	55+
SELF, FAMILY, FRIEND	166	35	14	211	10	1
HOSPITAL OUTPATIENT	5	2	1			
HOSPITAL OUTREACH	16	9	1			
SCHOOL OUTREACH				12	1	0
STATE HUMAN DEV. CENTER				13	1	0
TDMHMR INSTITUTION	1	2	0	32	6	2
OTHER MH INSTITUTION	19	6	0	0	0	0
OTHER MR INSTITUTION	0	1	0	10	1	0
COMMUNITY MHMR CENTER	58	13	3	299	7	1
NURSING HOME	0	0	0	3	0	0
COURT, LAW ENFORCEMENT	292	96	22	24	0	0
NON-PSYCHIATRIC PHYSICIAN	26	7	3	2	0	0
OTHER	17	4	0	187	13	3
NOT REPORTED	0	0	0	0	0	0
TOTAL	600	175	44	793	39	7

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a. Primary, secondary, tertiary diagnosis

FY 1975

TABLE 16

Contact Sources for Mental Retardates Served in Texas Community Programs

	ADMISSIONS TO REFERRED BY			INACTIVATIONS REFERRED TO		
AGE	34-54	55+	TOTALS	35-54	55+	TOTALS
SELF, FAMILY, FRIEND	181	32	213	1	1	2
CLERGY	4	1	5			
COURT, LAW ENFORCEMENT, CORRECTION AGENCY	17	2	19	1		1
PUBLIC SCHOOL SYSTEM	1		1			
FAMILY SERVICE, OTHER SOCIAL AGENCY	40	10	50	4	1	5
TDMHMR STATE HOSPITAL	63	17	80	23	6	29
OTHER PUBLIC PSYCHIATRIC HOSPITAL	4		4			
OTHER PSYCH. HOSP/GEN HOSP W/ PSYCH. SERVICE	6		6	1		1
OTHER HOSPITAL/MEDICAL FACILITY	7	2	9	2		2
TDMHMR STATE SCHOOL	49	17	66	10	2	12
OTHER MENTAL RETARDATION FACILITY	7		7	2		2
OTHER TDMHMR SERVICE	15	2	17	21	2	23
MENTAL HEALTH OUTPATIENT CENTER	5	1	6		1	1
TEXAS COMMUNITY MHMR CENTER	12	2	14	10	2	12
NON-MHMR CENTER EMERGENCY FACILITY						
VOCATIONAL REHAB. SERVICE FACILITY	24	4	28	6	2	8
PRIVATE PRACTICE MENTAL HEALTH PROFESSIONAL	4	1	5			
NON-PSYCHIATRIC PHYSICIAN	14	1	15	2		2
NURSING HOME	14	8	22	10	5	15
HALFWAY HOUSE	11	3	14	2		2
OTHER	16	2	18	11	4	15
NONE				7	1	8
UNKOWN	1	2	3			
NOT REPORTED	32	6	38	290	68	358
TOTAL	527	113	640	403	95	498

FY 1975

TABLE 17

Prevalence Mental Retardates[a] Discharges
Texas State Hospitals and Schools by Destination and Age Group

	STATE HOSPITALS			STATE SCHOOLS		
AGE	0-34	35-54	55+	0-34	35-54	55+
SELF, FAMILY, FRIEND	168	52	7	547	41	9
HOSPITAL OUTPATIENT	31	14	4			
HOSPITAL OUTREACH	79	56	12			
SCHOOL OUTREACH				5	1	0
STATE HUMAN DEV. CENTER				6	0	0
TDMHMR INSTITUTION	16	2	0	11	2	1
OTHER MH INSTITUTION	7	1	0	0	0	0
OTHER MR INSTITUTION	0	0	0	11	0	0
COMMUNITY MHMR CENTER	217	76	16	101	6	2
NURSING HOME	6	41	84	4	5	53
COURT, LAW ENFORCEMENT	16	2	0	8	0	0
NON-PSYCHIATRIC PHYSICIAN	10	6	7	0	0	0
OTHER	120	33	25	141	19	1
NOT REPORTED	8	1	0	0	1	0
TOTAL	678	284	155	834	75	66

a. Primary, secondary, tertiary diagnosis

FY 1975

FIGURES

FIGURE 1

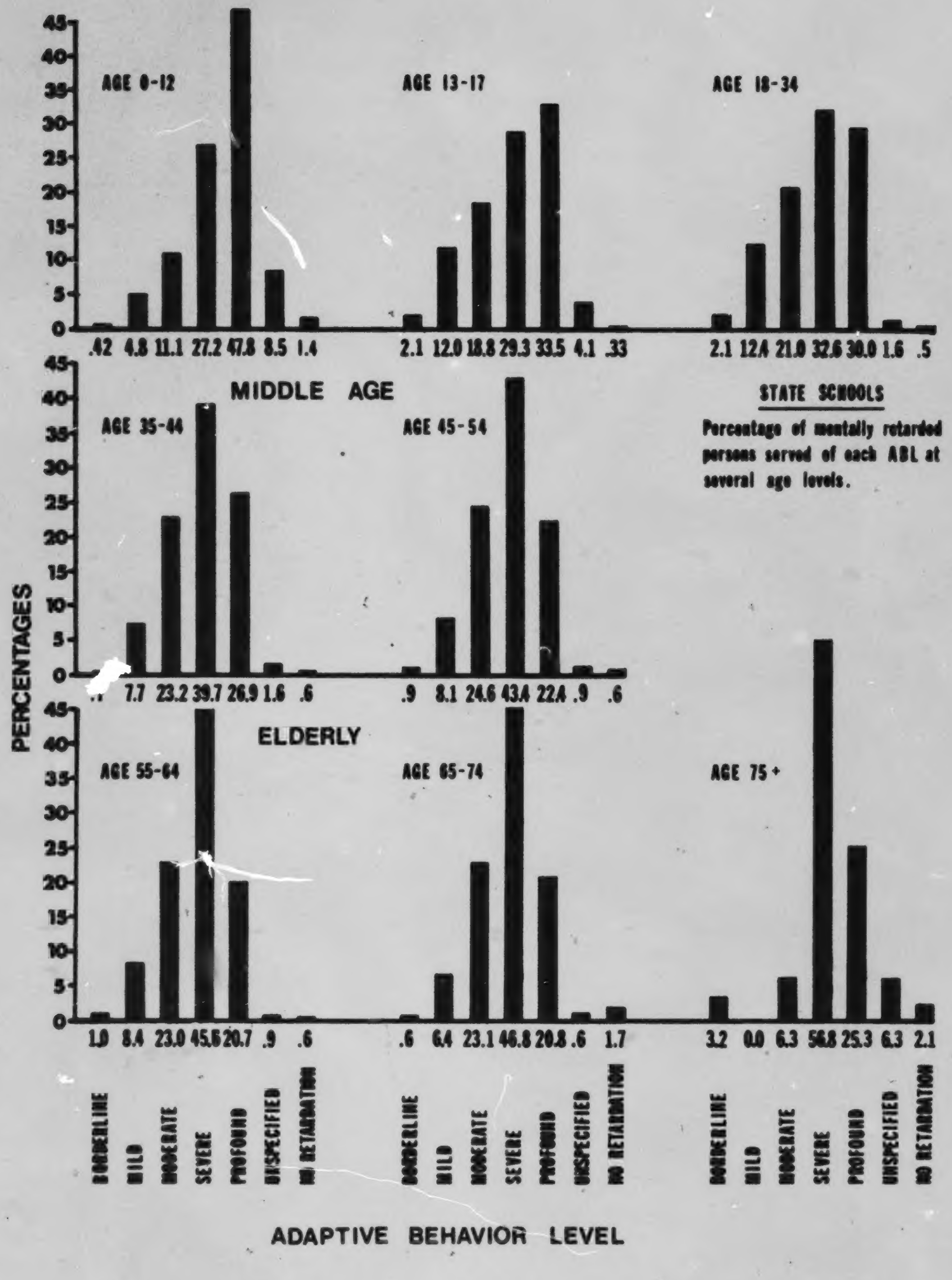
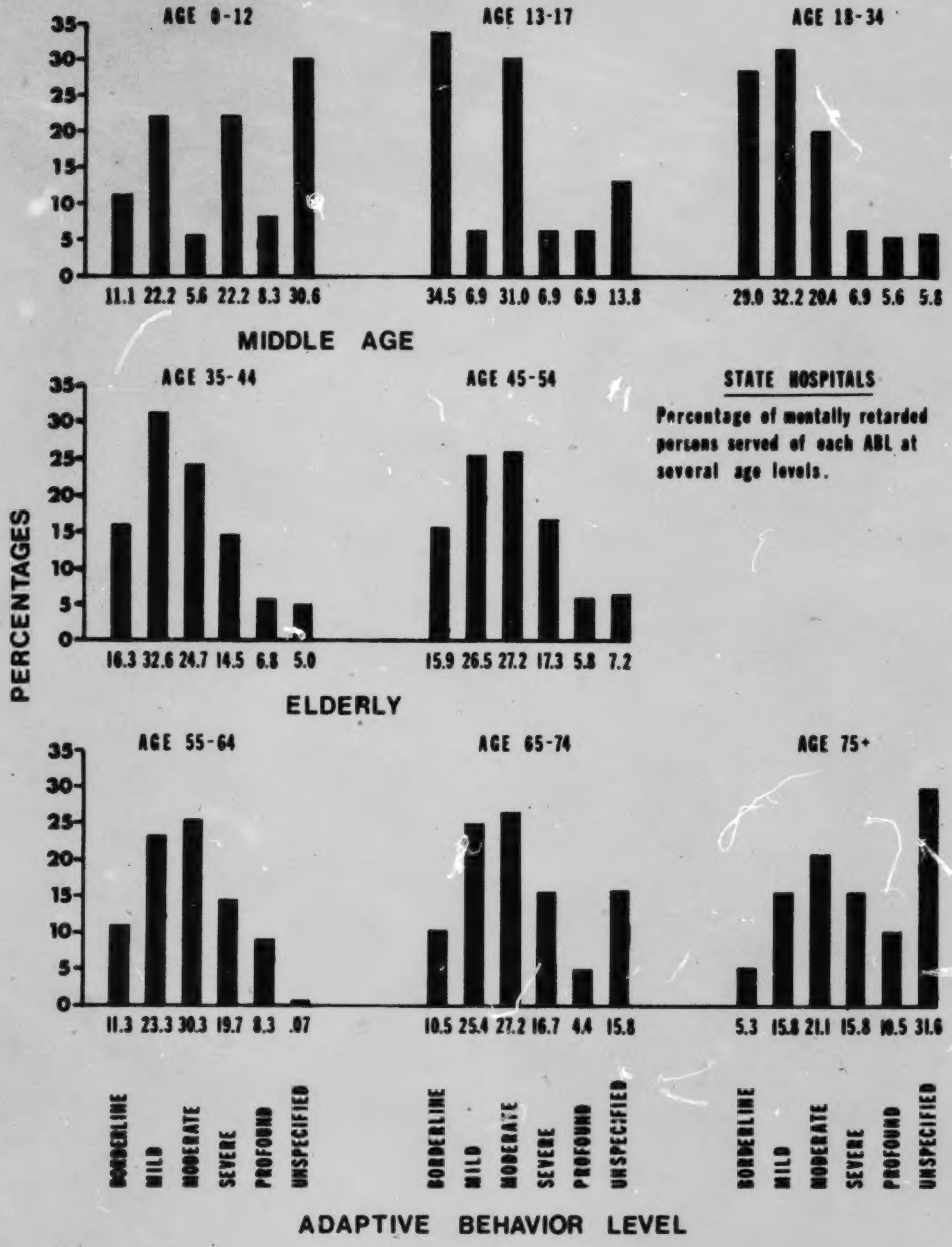

PERCENTAGES
45
40
35
30
25
20
15
10
5
0
AGE 0-12
.42 4.8 11.1 27.2 47.8 8.5 1.4
AGE 13-17
2.1 12.0 18.8 29.3 33.5 4.1 .33
AGE 18-34
2.1 12.4 21.0 32.6 30.0 1.6 .5
MIDDLE AGE
AGE 35-44
.1 7.7 23.2 39.7 26.9 1.6 .6
AGE 45-54
.9 8.1 24.6 43.4 22.4 .9 .6
STATE SCHOOLS
Percentage of mentally retarded persons served of each ABL at several age levels.
ELDERLY
AGE 55-64
1.0 8.4 23.0 45.6 20.7 .9 .6
AGE 65-74
.6 6.4 23.1 46.8 20.8 .6 1.7
AGE 75 +
3.2 0.0 6.3 56.8 25.3 6.3 2.1
BORDERLINE
MILD
MODERATE
SEVERE
PROFOUND
UNSPECIFIED
NO RETARDATION
ADAPTIVE BEHAVIOR LEVEL

FIGURE II



STATE HOSPITALS

Percentage of mentally retarded persons served of each ABL at several age levels.

APPENDIX A

EPIDEMIOLOGY and DEMOGRAPHY

APPENDIX A

EPIDEMIOLOGY AND DEMOGRAPHY

According to the American Association on Mental Deficiency (Grossman, 1973), mental retardation is defined as:

a. sub-average intellectual functioning (more than two standard deviations below normal),

b. evident before adulthood,

c. associated with impairment in adaptive behavior level (ABL).

This definition is the result of successive refinements (Heber, 1954, 1959) of early definitions (Doll, 1941; Juliana, 1975). Although there has been interest in separating inherited and environmental etiology (Mercer, 1973; Sarason, 1958), the AAMD definition is the most commonly accepted.

Classification Levels

Statistics in Texas are reported by ABL, measured by the Vineland Social Maturity Scale, and by I.Q. level as indicated by any individually administered I.Q. test. The four levels of retardation recognized by the AAMD and Heber's borderline retardation categories are:

Level of Retardation	I.Q. Range	
	Stanford Binet	Wechsler
Profound	0-19	0-24
Severe	20-35	25-39
Moderate	36-51	40-54
Mild	52-68	55-69
(Borderline)	(69-84)	(70-84)

A higher rate of mental retardation is reported for adults using I.Q. information rather than an index of social competence (Albizu-Miranda, Matlin and Stanton, 1966; Lemkau and Imre, 1966). The reverse is true for children (HEW, 1973a).

Causation

There are over 200 known causes of mental retardation (Heber, 1970), including over 60 genetic-metabolic errors (Emery, 1973; Koch, 1971). Mental retardation most commonly results from: Down's Syndrome (HEW, 1974; Penrose and Smith, 1966); phenylketonuria (Cunningham, 1971; Holtzman, 1974; Knox, 1972); Tay-Sacks Disease (Kaback, et.al., 1974); erythroblastosis fetalis or the extreme of the condition known as kernicterus, which results from Rh factor problems (Allen and Diamond, 1958; Clarke and McConnell, 1972; Diamond, 1968; Zimmerman, 1973); rubella (HEW, 1973b); maternal or childhood malnutrition (Birch, 1973); prematurity and low birth weight (Lubchenco, Delworia Papadapolous and Searles, 19720; lead poisoning (HEW, 1973b); and socio-cultural factors (Davies, 1959; Haywood, 1970; Heber and Garber, 1971; Nimnicht and Johnson, 1973). It has been estimated that 50 percent of all cases of mental retardation are preventable (Juliana, 1975).

All of the causes of mental retardation can be broadly classified into three major categories (Conley, 1973):

1. below average intellectual endowment,
2. full expression of inherited ability not attained because of environmental factors,
3. damage to central nervous system preventing full expression of inherited ability.

These categories are not mutually exclusive; usually mental retardation results from a combination of causes. Central nervous system pathology can be demonstrated in 15 percent of the mentally retarded (Heber, 1970). Minimal brain injury, diagnosed in substantially greater numbers of the general population, occurs at all I.Q. levels and, therefore, does not always result in a diagnosis of mental retardation (Robinson and Robinson, 1965).

Prevalence

The prevalence of mental retardation decreases with increasing age from fetal development (Bierman, 1955) to adolescence (Jostak, 1963; Lemkau and Imre, 1966; Lemkau, Tietze and Cooper, 1942; Levinson, 1962; Onondaga, MacPhee and Whitman, 1965; Richards, 1969; Taylor, 1965; Wishik, 1956), to middle and old age (Lemkau and Imre, 1966). An artificial peak at age 14 is indicated from surveys conducted in schools (California, 1965).

APPENDIX B

Persons Visited and Interviewed in Person and by Telephone

Visited:

Fort Worth, Denton, San Angelo, Lubbock, Brenham, Travis State Schools

Rio Grande Center, El Paso and Amarillo Human Development Centers

Community MHMR Centers in Harlingen, El Paso, Amarillo and Houston

Research and Development Center for Mental Retardation at Texas Tech University

Interviewed:

Mr. George Dryer, A Superintendent, San Angelo State School

Mr. Harry Hall, A Superintendent, San Angelo State School

Mr. Juan A. Amador, Director, MR Services, San Angelo State School

Mr. Fernandez, Director, Workshop and Activity Center, San Angelo State School

Ms. Carter Clopton, Director, Aged MR Services, TDMHMR Central Office

Dr. Dan Sheehan, Director, Support Services, TDMHMR Central Office

Dr. E. Craig, Director, Research, TDMHMR Central Office

Dr. J. Hale, Director, Program Development, MHMRA. Harris County

Dr. Kay Lewis, Director, Developmental Disabilities Clinic, TRIMS

Mr. Tom Thompson, Medical Services, DPW, Austin

Dr. Carol Whitcraft, Director, Research, Texas Rehab, Austin

Mr. Fred Krause, Executive Director, President's Committee on Mental Retardation

Dr. Sara F. Kriger, Director, MR Research, State of Ohio

Dr. Robert Segal, Program Director, Institute for MR, University of Michigan

Dr. Marvin Ernst, Dallas Geriatric Research Institute

Mr. Ed Bridges, Executive Director, Marbridge Foundation, Austin

Mr. David Sloane, Director, Texas Association Retarded Citizens, Austin

Dr. Phillip Roose, Executive Director, National Association Retarded Citizens, Arlington

Dr. Robert Cran, Superintendent, Northern Indiana State Hospital

Dr. Karl Chenoy, Northern Indiana State University

Dr. Wagner, Newcastle Hospital

Mr. Shelby Shedrick, Director, Programs for Older Residents

Dr. Cary Martin, Director, Research on Mental Retardates, University of Manitoba, Canada

Mr. Leon Evans, Director, Aged MR Programs, National Living Centers

Mr. Don Partridge, Director, Special Education, TEA, Austin

Ms. Sharon Brooks, Regional Resource Center, Child Find, Austin

Ms. Shirley Dean, East Nebraska Community Office for the Retarded (ENCOR)

Dr. Jon Hannu, Director, Dallas County MHMRA.

Dr. George Tarjan's secretary, President's Committee on Mental Retardation, California

Dr. Frank Borecca, Harris County Center for the Retarded

Dick Naylor, Director, Community Services, Denton

M. Barlow, Director, Nursing Services VII, Denton State School

Norm Schwolert, Unit I Supervisor, Denton State School

Patricia Griffin, Unit IV Supervisor, Denton State School

M. Preston, Director, Workshop/Work Activities Center, Denton State School

M. Sandborn, Director, Social Services, Denton State School

Lyn Wood, Program Coordinator, Home Management Education, Denton State School

Dr. Cecil Campbell, Residential Services Director, Fort Worth State School

Mr. Joe Miriscotti, Community Services Director, Fort Worth State School

Dr. Ronal Cookstone, Director, Programs, Fort Worth State School

Mr. Blas Cantu, Superintendent, Rio Grande Center

Dr. Myrna McMillan, Psychologist, Texas Tropical MHMR Center

Mr. Lee Prohead, Director MR, Texas Tropical MHMR Center

Ms. Becky Cortez, Supervisor, Brown's Outreach, RGSC MHMR

Ms. Ruth Blove, Director, Easter Seal Society, McCallen

Mr. Alfonzo Alamia, Psychologist, Rio Grande Center

Mr. Amme T. Kohler, Research Utilization Program, Administrator, Governor's Committee on Aging

Mr. Aurilio Valdez, Director, El Paso State Center

Mr. Ramirez, Director MR, El Paso State Center

Ms. Della Haddad, Executive Director, El Paso Center for MHMR Services

Dr. Henry Corte, Services, Lubbock State School

Ms. Julie Smith, MR Director, Lubbock MHMR Center

Molly Perez, Case Worker, Lubbock MHMR Center

Dr. Gerald Bensberg, Executive Director, R & T Center in MR, Texas Tech University

Dr. Carol Sigelman, Director of Research, R & T Center in MR, Texas Tech University

Dr. Bell, Project Research Director, Follow-up, R & T Center in MR, Texas Tech University

Ms. Carol Shoenrock, Assistant Coordinator, R & T Center in MR, Texas Tech University

Mr. Harry Haymond, Director, Amarillo State Center

Ms. Marjorie Kruckeberg, Director, Social Services, Amarillo State Center

Mr. Clarke Woldridge, Administrator, MHMR Regional Center, Amarillo

Dick Wray, Assistant Administrator, Childrens Psychiatric Hospital, Amarillo

Helen Lowe, Director, Nursing, Pavillion Psychiatric Hospital, Amarillo

Dr. Velma Schmidt, NTSU, Denton

Dr. J. Curry, Director, Research, NTSU

Dr. W. K. Brookshire, NTSU

APPENDIX C

Resident Movement by Age Group By ABL
for Each of the State Schools in Texas.

TEXAS STATE SCHOOLS FY 1975 ADMISSIONS
MENTAL RETARDATION PATIENTS

Level of
Mental
Retardation

Age 0-12	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	150	31	3	50	1	19		15		4	6	20	1
BORDERLINE	3			1							2		
MILD	13	2		1	1	2				4			3
MODERATE	42	2		10		3		11		7		2	7
SEVERE	84	8	1	12	4	4		14	3	12	2	3	21
PROFOUND	89	14	12	15	4	11		3	11	7	2	6	4
NO RETAR.	1									1			
TOTALS	382	57	16	89	10	39		43	14	35	12	31	36

Age 13-17	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	84	13		18		7		10	1	2	6	27	
BORDERLINE	6			1	1						3	1	
MILD	28	4		6	1			2		2	7	2	4
MODERATE	28	2		2	2	2		6	2	2	4	2	4
SEVERE	26	4		2	2			6	1	1	4	2	4
PROFOUND	18	3	3	2		3		1	3	2		1	
NO RETAR.	1	1											
TOTALS	191	27	3	31	6	12		25	7	9	24	35	12

Age 18-34	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	61	15		6		15	1	2	2	2	2	11	5
BORDERLINE	14			6							8		
MILD	36	3		10				6		4	7	6	
MODERATE	23	1		3	2	3	1	5		2	4	2	
SEVERE	23	4		1	2	2		5	2	1	2	2	2
PROFOUND	20	3	3	4		1		2	3		1	2	1
NO RETAR.	2			1						1			
TOTALS	179	26	3	31	4	21	2	20	7	10	24	23	8

Age 35-44	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	7			1	1		4		1				
BORDERLINE	1										1		
MILD	1								1				
MODERATE	3	1					2						
SEVERE	8			1	2			1	2	1			1
PROFOUND	5	1								2	1	1	
NO RETAR.													
TOTALS	25	2		2	3		6	1	4	3	2	1	1

TEXAS STATE SCHOOLS FY 1975: ADMISSIONS
MENTAL RETARDATION PATIENTS

Level of
Mental
Retardation

Age 45-54	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	1					1							
BORDERLINE													
MILD	4				1		3						
MODERATE	1						1						
SEVERE	3						2			1			
PROFOUND	4			1				2			1		
NO RETAR.													
TOTALS	13			1	1	1	6	2		1	1		

Age 55-64	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	1						1						
BORDERLINE													
MILD	2						1	1					
MODERATE	1						1						
SEVERE													
PROFOUND	2								1	1			
NO RETAR.													
TOTALS	6						3	1	1	1			

Age 65-74	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK													
BORDERLINE													
MILD	1						1						
MODERATE													
SEVERE													
PROFOUND													
NO RETAR.													
TOTALS	1						1						

Age 75+	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK													
BORDERLINE													
MILD													
MODERATE													
SEVERE													
PROFOUND													
NO RETAR.													
TOTALS													

	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
TOTALS	797	112	22	154	24	73	18	92	33	59	63	90	57

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.TEXAS STATE SCHOOLS FY 1975, SERVED
MENTAL RETARDATION PATIENTS

Level of
Mental
Retardation

Age 0-12	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	180	36	3	62	1	21		16		5	8	27	1
BORDERLINE	9			1	1			1			2	3	1
MILD	102	18		14	10	12		13		20	4	3	8
MODERATE	237	19		33	23	17		45	3	39	13	27	18
SEVERE	578	51	1	68	70	66		51	20	107	56	43	45
PROFOUND	1017	213	12	205	58	120		35	59	91	83	119	22
NO RETAR.	3									2		1	
TOTALS	2126	237	16	383	163	236		161	82	264	166	223	95

Age 13-17	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	100	19		18		11		11	2	1	6	26	6
BORDERLINE	52	4		2	5	3		5	1	4	14	14	
MILD	293	44		17	23	11		55	1	61	32	29	20
MODERATE	[illegible]	52		30	40	21		96	20	60	70	48	23
SEVERE	717	72		64	117	55		77	36	108	134	40	14
PROFOUND	621	193	5	128	56	66		55	83	53	108	63	11
NO RETAR.	8	2		1						4		1	
TOTALS	2451	386	5	260	241	167		299	143	291	364	221	74

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Age 18-34	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	95	27		11		14	1	6	8	4	9	14	1
BORDERLINE	124	25		22	3	3		21		7	24	18	1
MILD	732	189	1	58	56	12	10	116	4	75	113	85	13
MODERATE	1235	215		101	51	39	19	212	124	134	185	63	52
SEVERE	1909	201		189	205	96	17	301	206	309	243	68	74
PROFOUND	1761	313	7	99	64	114	1	351	288	161	254	71	38
NO RETAR.	29	11		1	1			5		2	5	4	
TOTALS	5865	581	8	481	420	278	40	1012	630	692	833	323	179

Age 35-44	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	16	1		2	1		8		3	1			
BORDERLINE	10	1						3		1	4	1	
MILD	108	17		2	3		19	28	5	24	5	4	1
MODERATE	325	11		21	11	2	77	61	70	36	23		13
SEVERE	556	8		24	70	2	56	112	119	109	40	1	15
PROFOUND	376	35	1	10	12	1	4	109	124	47	24	3	6
NO RETAR.	8	3			2					1	2		
TOTALS	1399	76	1	59	99	5	164	313	321	219	98	5	35

TEXAS STATE SCHOOLS FY 1975 SERVED
MENTAL RETARDATION PATIENTS

Level of Mental Retardation

Age 45-54	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	11	1				1	5	1	2		1		
BORDERLINE	11						3			5	3		
MILD	100	2		2	9		14	20	8	27	17		1
MODERATE	252	5		6	6		117	31	71	34	21		1
SEVERE	536			5	46		137	66	117	111	46		8
PROFOUND	277	15		4	3		13	100	89	31	18		4
NO RETAR.	8	1			1			4		2			
TOTALS	1235	24		17	65	1	289	222	287	210	106		14

Age 55-64	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	7			1			3	1	2				
BORDERLINE	8						4	1		1	2		
MILD	69	1			2		25	8	7	17	9		
MODERATE	188			1	2		90	17	31	33	14		
SEVERE	373	3		6	13		86	75	80	75	34		1
PROFOUND	169	5	1	1	4		13	64	55	20	6		
NO RETAR.	4							1		3			
TOTALS	818	9	1	9	21		221	167	175	149	65		1

Age 65-74	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	2								1	1			
BORDERLINE	2									2			
MILD	22						5	4	3	8	2		
MODERATE	80						31	12	7	25	5		
SEVERE	162	1	1				19	47	31	56	7		
PROFOUND	72	1	1				1	32	28	8	1		
NO RETAR.	6									6			
TOTALS	346	2	2				56	95	70	106	15		

Age 75+	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	6									6			
BORDERLINE	3								1	1	1		
MILD													
MODERATE	6							2		4			
SEVERE	54	1						29	11	13			
PROFOUND	24							18	3	3			
NO RETAR.	2									2			
TOTALS	55	1						49	15	29	1		

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	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
TOTALS	14355	1816	33	1209	1009	687	778	2318	1723	1960	1648	776	398

TEXAS STATE SCHOOLS FY 1975, BOOK POPULATION
MENTAL RETARDATION PATIENTS

Level of Mental Retardation

Age 0-12

	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	14	4		4				1			1	4	
BORDERLINE	5			1							2	1	1
MILD	70	15		8	6	9		9		15		2	6
MODERATE	160	12		23	13	9		29	2	33	8	17	14
SEVERE	434	42	1	57	46	49		36	16	82	35	32	36
PROFOUND	820	172	9	166	49	96		28	43	79	56	104	18
NO RETAR.	2									1		1	
TOTALS	1505	245	10	259	114	163		103	61	210	102	161	77

Age 13-17

	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	13	1		4		1		2				4	1
BORDERLINE	29	4		1	2	2		3		1	6	10	
MILD	197	31		12	20	10		35		32	20	20	17
MODERATE	386	37		30	42	15		83	15	45	53	46	20
SEVERE	622	55		58	109	45		65	27	102	109	37	15
PROFOUND	741	169	3	125	52	53		42	72	51	100	61	8
NO RETAR.	4									3		1	
TOTALS	1992	297	3	230	225	131		230	114	234	288	179	61

Age 18-34

	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	35	13		5		2		5	4		1	3	2
BORDERLINE	104	23		11	3	4		14		10	23	16	
MILD	637	183	1	46	52	13	9	86	4	63	88	76	16
MODERATE	1192	224		93	78	42	15	199	120	128	172	66	55
SEVERE	1939	217		193	210	99	16	281	200	313	261	74	75
PROFOUND	1816	336	8	116	72	122	1	324	299	154	269	76	39
NO RETAR.	19	10		1	1			1		2	1	3	
TOTALS	5742	1006	9	465	416	282	41	910	627	670	815	314	187

Age 35-44

	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	11	1		1			7		1	1			
BORDERLINE	10	1			1			2		1	4	1	
MILD	103	20		2	3		18	24	4	21	5	5	1
MODERATE	315	16		24	13	3	72	55	67	33	21		11
SEVERE	529	10		26	70	3	46	101	120	97	37	1	18
PROFOUND	361	31	1	11	11	3	2	109	119	41	23	3	7
NO RETAR.	3	2									1		
TOTALS	1332	81	1	64	98	9	145	291	311	194	91	10	37

TEXAS STATE SCHOOLS FY 1975, BOOK POPULATION
MENTAL RETARDATION PATIENTS

Level of Mental Retardation

Age 45-54	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	5	1				1	2		1				
BORDERLINE	10	1					3			4	2		
MILD	81	3		2	10		11	14	8	19	13		1
MODERATE	284	5		6	6		107	25	74	35	22		4
SEVERE	528			6	47		128	70	113	110	47		7
PROFOUND	285	20		5	4		15	104	85	35	14		3
NO RETAR.	4	1								3			
TOTALS	1197	31		19	67	1	266	213	281	206	98		15

Age 55-64	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	5						4			—	1		
BORDERLINE	9						4			2	3		
MILD	71	1			2		24	8	6	22	8		
MODERATE	186			1	2		96	13	28	31	15		
SEVERE	370	3		6	14		90	71	81	71	33		1
PROFOUND	169	4		1	4		12	59	59	19	10		1
NO RETAR.	3				1					2			
TOTALS	813	8		8	23		230	151	174	147	70		2

Age 65-74	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK													
BORDERLINE													
MILD	24						7	4	3	7	3		
MODERATE	68						32	6	11	15	4		
SEVERE	167		1		1		23	46	31	56	9		
PROFOUND	62		2				1	27	22	9	1		
NO RETAR.	2									2			
TOTALS	323		3		1		63	83	67	89	17		

Age 75+	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK													
BORDERLINE	2								1		1		
MILD													
MODERATE	8						1	3		3	1		
SEVERE	56	1					2	26	12	14	1		
PROFOUND	20							16	2	2			
NO RETAR.	2									2			
TOTALS	88	1					3	45	15	21	3		

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	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
TOTALS	12992	1669	26	1045	944	586	748	2026	1650	1771	1484	664	379

TEXAS STATE SCHOOLS FY 1975 LIVE DISCHARGES
MENTAL RETARDATION PATIENTS

Level of
Mental
Retardation

Age 0-12	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	146	31	3	51	1	20		14		4	6	15	1
BORDERLINE	3							1				2	
MILD	11	1		2		1		1		2	2	1	1
MODERATE	16	2		4	1	3		2		1	1	2	
SEVERE	26	2		4	2	5		6	1	2	2	1	1
PROFOUND	25	2	3	10		4		1		1	2		2
NO RETAR.													
TOTALS	227	38	6	71	4	33		25	1	10	13	21	5

Age 13-17	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	81	15		18		7		9		2	6	24	
BORDERLINE	8				3			2	1		1	1	
MILD	38	2		3	1			9		14	6	3	
MODERATE	21	1		1	2	2		4	1	1	4	4	1
SEVERE	26	1			5	10		3	1	1	4	1	
PROFOUND	11			3		4		1			2		1
NO RETAR.	4	1		1						2			
TOTALS	189	20		26	11	23		28	3	20	23	33	2

ge 18-34	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	61	16		6		15		1	2	2	4	11	4
BORDERLINE	30	1		12				7			7	3	
MILD	139	10		16	6	1		37	1	23	30	14	1
MODERATE	81	4		9	6	4		22	1	15	18	2	
SEVERE	43			2	6	6		9	2	7	8	3	
PROFOUND	14	1		3	1	5			1	1		2	
NO RETAR.	10	1						4			4	1	
TOTALS	378	33		48	19	31		80	7	48	71	36	5

ge 35-44	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	4			1	1		2						
BORDERLINE	1							1					
MILD	8			1			1	1	1	3	1		
MODERATE	9							5	1	1	2		
SEVERE	7							4	1	1	1		
PROFOUND	3	1						1			1		
NO RETAR.	4	1			2						1		
TOTALS	36	2		2	3		3	12	3	5	6		

TEXAS STATE SCHOOLS FY 1975: LIVE DISCHARGES
MENTAL RETARDATION PATIENTS

Level of
Mental
Retardation

Age 45-54	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK													
BORDERLINE													
MILD	12						2	6		2	2		
MODERATE	11			1			2	7	1				
SEVERE	6							4		2			
PROFOUND	3							1	1		1		
NO RETAR.	4							4					
TOTALS	36			1			4	22	2	4	3		

Age 55-64	TOTALS	66C	667	668	669	670	671	672	675	676	678	687	688
BLANK	1							1					
BORDERLINE	1							1					
MILD	4								1	1	2		
MODERATE	8							4	2	2			
SEVERE	3						1	1			1		
PROFOUND													
NO RETAR.	2							1		1			
TOTALS	19						1	8	3	4	3		

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Age 65-74	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	1									1			
BORDERLINE	1									1			
MILD	2							1		1			
MODERATE	14							4	1	9			
SEVERE	5							3	1	1			
PROFOUND	1								1				
NO RETAR.	3									3			
TOTALS	27							8	3	16			

Age 75+	TOTALS	DENTON	FORT WORTH	RICH-MOND	LUFKIN	CORPUS CHRISTI	SAN ANGELO	MEXIA	TRAVIS	ABILENE	AUSTIN	LUBBOCK	BRENHAM
BLANK	5									5			
BORDERLINE	2									2			
MILD	1							1					
MODERATE	3							1		2			
SEVERE	7							3	1	3			
PROFOUND	1									1			
NO RETAR.	1									1			
TOTALS	20							5	1	14			
TOTALS 70	532	93	6	148	37	87	8	188	23	121	119	9C	12

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APPENDIX D

Patient Movement By Age Group By ABL
for Each of the State Mental Hospitals in Texas

ADMISSIONS FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
AGE 0-12											
BORDERLINE											
MILD	6				3		1		2		
MODERATE	2				1				1		
SEVERE	5				4			1			
PROFOUND	3				3						
UNSPECIFIED	10				7		3				
TOTAL	26				18		4	1	3		
AGE 13-17											
BORDERLINE	6	2				2	1			1	
MILD	1				1						
MODERATE	7	1				1		4			1
SEVERE	1				1						
PROFOUND	2				2						
UNSPECIFIED	3				3						
TOTAL	20	3			7	3	1	4		1	1
AGE 18-34											
BORDERLINE	233	36		1	51	44	22	60	6	5	8
MILD	245	23	4	4	64	42	19	56	12	4	17
MODERATE	135	9	3		41	10	13	28	11	3	17
SEVERE	44	1			31	2	5	2	1		2
PROFOUND	50				47		1	1			1
UNSPECIFIED	57		4		30	5	13	1		4	
TOTAL	764	69	11	5	264	103	73	148	30	16	45
AGE 35-44											
BORDERLINE	32	2		2	7	8	2	10			1
MILD	47	4		1	7	10	7	9	3		6
MODERATE	27	2			10	2	1	7	1		4
SEVERE	9				5	1	1	1			1
PROFOUND	14	1			12	1					
UNSPECIFIED	11		1		3	1	4	1	1		
TOTAL	140	9	1	3	44	23	15	28	5		12
AGE 45-54											
BORDERLINE	20	1			3	5	3	8			
MILD	27	2	1		7	7	2	5	1		2
MODERATE	27	1	1		10	7	2	5			1
SEVERE	13				10	1		1			1
PROFOUND	9				8			1			
UNSPECIFIED	10				4	2	3	1			
TOTAL	106	4	2		42	22	10	21	1		4
AGE 55-64											
BORDERLINE	14	3			2	6		3			
MILD	11	2			2	2		4			1
MODERATE	21	2			12	1	2	1	1		2
SEVERE	14			2	10			1			1
PROFOUND	5	1			4						
UNSPECIFIED	4				1		2				1
TOTAL		8		2	31	9	4	9	1		5
AGE 65-74											
BORDERLINE	6				1			5			
MILD	5				3			1	1		
MODERATE	8				6				1		1
SEVERE	5				5						
PROFOUND	3				3						
UNSPECIFIED	2				1						1
TOTAL	29				19			6	2		2
AGE 75+											
BORDERLINE											
MILD	1				1						
MODERATE											
SEVERE	1				1						
PROFOUND	2				2						
UNSPECIFIED											
TOTAL	4				4						
GRAND TOTAL	1158	93	14	10	429	160	107	217	42	17	69

*Primary, secondary or tertiary

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RESIDENTS AUGUST 31, 1975
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
AGE 0-12											
BORDERLINE	1								1		
MILD											
MODERATE											
SEVERE											
PROFOUND											
UNSPECIFIED											
TOTAL	1								1		
AGE 13-17											
BORDERLINE	4	2					1				1
MILD											
MODERATE	2							2			
SEVERE											
PROFOUND											
UNSPECIFIED	1				1						
TOTAL	7	2			1		1	2			1
AGE 18-34											
BORDERLINE	108	32			7	30	8	25	1		5
MILD	144	15	1	1	10	32	10	47	4		24
MODERATE	99	4			13	11	15	26	9	2	19
SEVERE	39	1	1			4	10	9	3		11
PROFOUND	22	2				1	7	5	2		5
UNSPECIFIED	13		1		2	1	3	2	3		1
TOTAL	425	54	3	1	32	79	53	114	22	2	65
AGE 35-44											
BORDERLINE	19				3	8		7			1
MILD	47	3		1	3	7	9	19	1		4
MODERATE	48	6			6	11	2	13	6		4
SEVERE	41				3	4	13	12	6		3
PROFOUND	8	3			1	2	1	1			
UNSPECIFIED	5		1				2		2		
TOTAL	168	12	1	1	16	32	27	52	15		12
AGE 45-54											
BORDERLINE	24	3		1		2	5	13			
MILD	55	10		2	5	11	1	17	4		5
MODERATE	60	7		2	6	11	8	14	6		6
SEVERE	40			1	8	6	7	9	7		2
PROFOUND	10	2				3	4		1		
UNSPECIFIED	21			1	2	2	8	1	7		
TOTAL	210	22		7	21	35	33	54	25		13
AGE 55-64											
BORDERLINE	16	7				4		4			1
MILD	37	10		1	6	3	1	12	3		1
MODERATE	45	7		2	2	10	3	12	7		2
SEVERE	34			2	5	3	11	6	3		4
PROFOUND	14	6					3	2	3		
UNSPECIFIED	13			1		1	5		4		2
TOTAL	159	30		6	13	21	23	36	20		10
AGE 65-74											
BORDERLINE	7	1		2		1		3			
MILD	11			3		1		6	1		
MODERATE	12					5		3	2		2
SEVERE	7	1		1	1	2	1	1			
PROFOUND											
UNSPECIFIED	8			1		1			4		2
TOTAL	45	2		7	1	10	1	13	7		4
AGE 75+											
BORDERLINE											
MILD											
MODERATE	1			1							
SEVERE											
PROFOUND											
UNSPECIFIED											
TOTAL	1			1							
GRAND TOTAL	1016	122	4	23	84	177	138	271	90	2	105

*Primary, secondary or tertiary

SERVED FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
AGE 0-12											
BORDERLINE	4	1			1				2		
MILD	8				3		1		4		
MODERATE	2				1				1		
SEVERE	8				6			1	1		
PROFOUND	3				3						
UNSPECIFIED	11				8		3				
TOTAL	36	1			22		4	1	8		
AGE 13-17											
BORDERLINE	10	3				2	2			1	2
MILD	2				1				1		
MODERATE	9	1			1	1	1	4			1
SEVERE	2				1			1			
PROFOUND	2				2						
UNSPECIFIED	4				4						
TOTAL	29	4			9	3	3	5	1	1	3
AGE 18-34											
BORDERLINE	383	71		1	65	82	35	94	14	6	15
MILD	425	27	5	5	81	85	34	116	26	4	42
MODERATE	269	13	4	1	56	36	32	65	20	3	39
SEVERE	91	1	1		31	7	19	14	6		12
PROFOUND	74	2			48	1	8	8	2		5
UNSPECIFIED	77		6		33	8	17	3	5	4	1
TOTAL	1319	114	16	7	314	219	145	300	73	17	114
AGE 35-44											
BORDERLINE	62	2		2	9	21	4	21	1		2
MILD	124	5	1	1	15	24	21	35	11		11
MODERATE	94	9		1	16	19	4	26	8		11
SEVERE	55				8	7	14	15	8		3
PROFOUND	26	3			12	4	3	1			3
UNSPECIFIED	19	1	1		3	1	7	1	5		
TOTAL	380	20	2	4	63	76	53	99	33		30
AGE 45-54											
BORDERLINE	66	4		1	5	17	15	23	1		
MILD	110	11	1	3	14	24	6	29	13		9
MODERATE	113	8	2	2	22	29	15	20	6		9
SEVERE	72			1	19	13	17	12	8		2
PROFOUND	24	2			9	5	6	1	1		
UNSPECIFIED	30	1		1	6	4	9	2	7		
TOTAL	415	26	3	8	75	92	68	87	36		20
AGE 55-64											
BORDERLINE	34	9			3	8	4	9			1
MILD	70	10		1	12	10	8	21	5		3
MODERATE	91	10		3	14	18	14	21	8		3
SEVERE	59			3	17	5	17	10	3		4
PROFOUND	25	6			4	2	6	3	4		
UNSPECIFIED	21			2	1	2	8		5		3
TOTAL	300	35		9	51	45	57	64	25		14
AGE 65-74											
BORDERLINE	12			2	1	1	1	7			
MILD	29	1		3	3	1	5	9	7		
MODERATE	31				6	8	1	9	5		2
SEVERE	19	1		1	7	2	3	2	3		
PROFOUND	5				3		2				
UNSPECIFIED	18	2		1	1	1	3		8		2
TOTAL	114	4		7	21	13	15	27	23		4
AGE 75+											
BORDERLINE	1						1				
MILD	3				1			1	1		
MODERATE	4			3					1		
SEVERE	3				1		2				
PROFOUND	2				2						
UNSPECIFIED	6	2				1	1		2		
TOTAL	19	2		3	4	1	4	1	4		
GRAND TOTAL	2612	206	21	38	559	449	349	584	203	18	185

*Primary, secondary or tertiary

Program Analysis and

DIACHARGES FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MEN. RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
AGE 0-12											
BORDERLINE	3	1			1				1		
MILD	7				3		1		3		
MODERATE	2				1				1		
SEVERE	8				6			1	1		
PROFOUND	3				3						
UNSPECIFIED	11				8		3				
TOTAL	34	1			22		4	1	6		
AGE 13-17											
BORDERLINE	7	1				2	1			1	2
MILD	2				1				1		
MODERATE	6	1			1	1	1	2			
SEVERE	2				1			1			
PROFOUND	2				2						
UNSPECIFIED	3				3						
TOTAL	22	2			8	3	2	3	1	1	2
AGE 18-34											
BORDERLINE	259	38		1	57	48	24	64	12	6	9
MILD	262	12	4	4	69	47	21	62	21	4	18
MODERATE	165	9	3	1	43	25	17	38	10	1	18
SEVERE	50				30	3	8	5	3		1
PROFOUND	52				48		1	3			
UNSPECIFIED	63		5		31	7	14	1	1	4	
TOTAL	851	59	12	6	278	130	85	173	47	15	46
AGE 35-44											
BORDERLINE	40	2		2	5	12	4	13	1		1
MILD	68	2	1		10	16	10	15	7		7
MODERATE	46	3		1	10	8	2	13	2		7
SEVERE	12				4	3	1	2	2		
PROFOUND	18				11	2	2				3
UNSPECIFIED	13	1			3	1	5	1	2		
TOTAL	197	8	1	3	43	42	24	44	14		18
AGE 45-54											
BORDERLINE	37	1			5	13	8	9	1		
MILD	47	1	1		8	12	5	11	5		4
MODERATE	49		2		16	15	7	6			3
SEVERE	31				11	6	10	3	1		
PROFOUND	12				9		2	1			
UNSPECIFIED	9	1			4	2	1	1			
TOTAL	185	3	3		53	48	33	31	7		7
AGE 55-64											
BORDERLINE	18	2			3	4	4	5			
MILD	29				6	7	6	8			2
MODERATE	45	3		1	11	8	11	9	1		1
SEVERE	25			1	12	2	6	4			
PROFOUND	20				4	2	3	1	1		
UNSPECIFIED	7			1	1	1	3				1
TOTAL	135	5		3	37	24	33	27	2		4
AGE 65-74											
BORDERLINE	6				1		1	4			
MILD	12				3		5	3	1		
MODERATE	18				6	3	1	5	3		
SEVERE	12				6		2	1	3		
PROFOUND	5				3		2				
UNSPECIFIED	9	2			1		3		3		
TOTAL	62	2			20	3	14	13	10		
AGE 75+											
BORDERLINE	1						1				
MILD	3				1			1	1		
MODERATE	2			2							
SEVERE	3				1		2				
PROFOUND	2				2						
UNSPECIFIED	5	2					1		2		
TOTAL	16	2		2	4		4	1	3		
GRAND TOTAL	1502	82	16	14	465	250	199	293	90	16	77

*Primary, secondary or tertiary

Program Analysis and

ADMISSIONS FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
BORDERLINE	311	44		3	64	65	28	86	6	6	9
MILD	343	31	5	5	88	61	29	75	19	4	26
MODERATE	227	15	4		80	21	18	45	15	3	26
SEVERE	92	1		2	67	4	6	6	1		5
PROFOUND	88	2			81	1	1	2			1
UNSPECIFIED	97		5		49	8	25	3	1	4	2
TOTAL	1158	93	14	10	429	160	107	217	42	17	69

*Primary, secondary or tertiary

Program Analysis and
Statistical Research
April, 1976

RESIDENTS AUGUST 31, 1975
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
BORDERLINE	177	44		3	10	45	14	52	2		7
MILD	295	39	1	8	24	54	21	101	13		34
MODERATE	268	24		5	27	48	28	70	30	2	34
SEVERE	161	2	1	4	17	19	42	37	19		20
PROFOUND	54	13			1	6	15	8	6		5
UNSPECIFIED	61		2	3	5	5	18	3	20		5
TOTAL	1016	122	4	23	84	177	138	271	90	2	105

*Primary, secondary or tertiary

Program Analysis and
Statistical Research
April, 1976

SERVED FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
BORDERLINE	572	90		6	84	131	62	154	18	7	20
MILD	771	54	7	13	130	144	75	211	68	4	65
MODERATE	613	41	6	10	116	111	67	145	49	3	65
SEVERE	309	2	1	5	90	34	72	55	29		21
PROFOUND	161	13			83	12	25	13	7		8
UNSPECIFIED	186	6	7	4	56	17	48	6	32	4	6
TOTAL	2612	206	21	38	559	449	349	584	203	18	185

*Primary, secondary or tertiary

Program Analysis and
Statistical Research
April, 1976

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DISCHARGES FY75
TEXAS STATE HOSPITALS
PATIENTS WITH A DIAGNOSIS* OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	TOTAL	VERNON	RIO GRAN.	KERRVILLE	AUSTIN	RUSK	SAN ANTONIO	TERRELL	WICHITA FALLS	TRIMS	BIG SPRING
BORDERLINE	371	45		3	72	79	43	95	15	7	12
MILD	430	15	6	4	101	82	48	100	39	4	31
MODERATE	333	16	5	5	88	60	39	73	17	1	29
SEVERE	143			1	71	14	29	17	10		1
PROFOUND	105				82	4	10	5	1		3
UNSPECIFIED	120	6	5	1	51	11	30	3	8	4	1
TOTAL	1502	82	16	14	465	250	199	293	90	16	77

*Primary, secondary or tertiary

Program Analysis and
Statistical Research
April, 1976

APPENDIX E

Texas Tech University

Research Training Center in Mental Retardation

Dr. Nancy Bell
Research Scientist

Dr. Carol Schoenrock
Assistant Coordinator

Ms. Linda Smith
Research Assistant

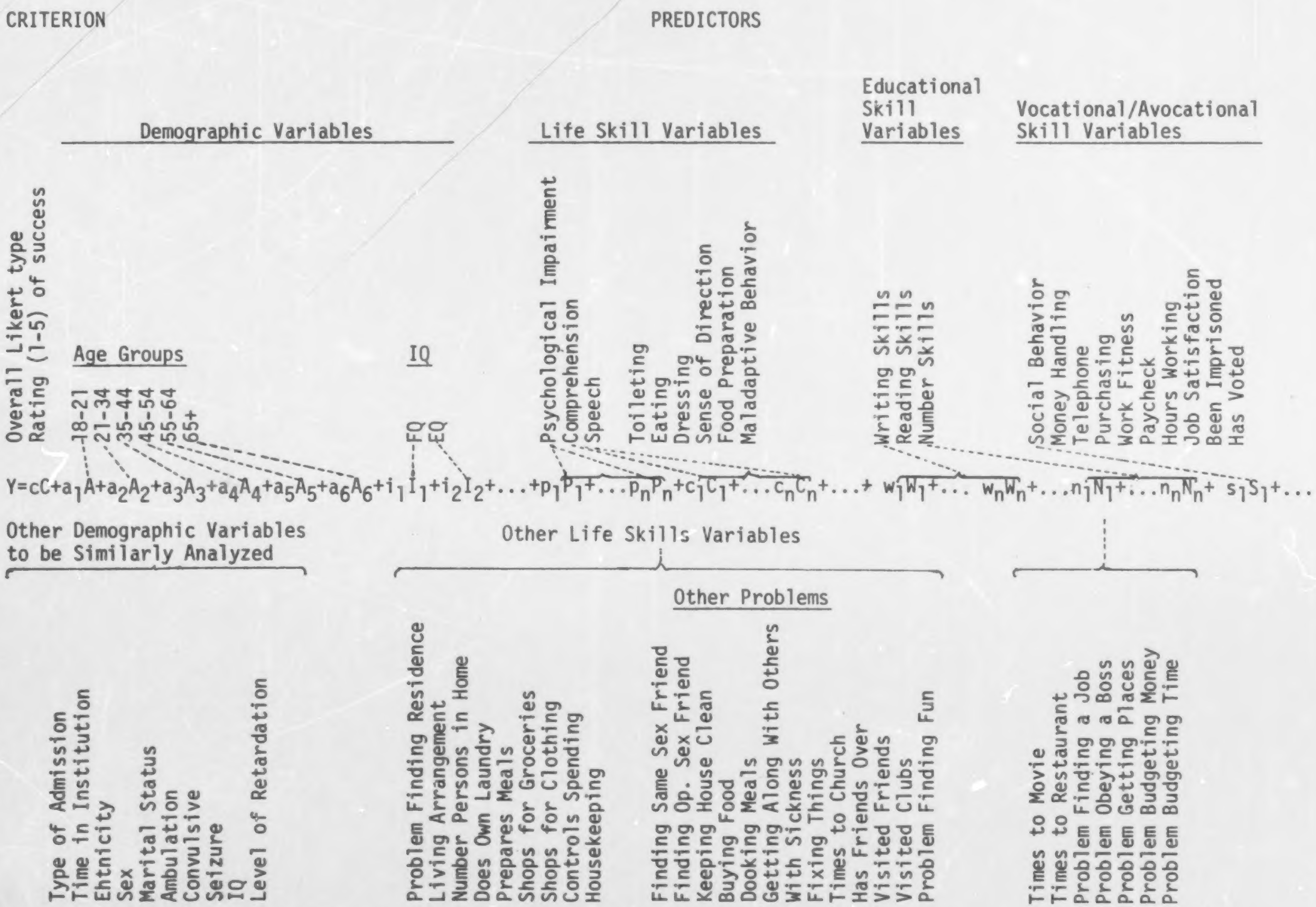
In the fall of 1973, 503 persons were selected by a stratified random sampling procedure. Stratifications were made according to the figures of each of the five previous years in terms of numbers discharged, the institution discharged from, and the ability level of the persons. Training of the discharged persons and settings in which they were placed varied. Preliminary results have been reported (Bell, 1976; Bell, Shoenrock and Hromas, 1976).

Questionaires were mailed to 503 persons discharged from state schools. Two thirds had I.Q. scores above 55 and were mailed the questionnaire directly; the remaining questionnaires were mailed to the guardians. Following a 34 percent return rate, 80 personal interviews were held, one half with those returning the questionnaire and one half with those not returning them. In addition to questionnaire responses, background data was supplied by the schools.

Included in this appendix is a table presenting the post-discharge data. It is recommended that the data be analyzed via Multilinear Regression Analyses (Ward and Jennings, 1973). A format is suggested on the next page.

This data presents a unique opportunity to analyse the components of community life style by age group. Answers can be sought to the following kind of question. Which mentally retarded persons with which demographic characteristics, with which living, learning, working and liesure skills are most likely to succeed in which settings.

MULTILINEAR REGRESSION ANALYSIS


CRITERION
PREDICTORS
Overall Likert type Rating (1-5) of success
Demographic Variables
Age Groups
18-21
21-34
35-44
45-54
55-64
65+
IQ
FQ
EQ
Life Skill Variables
Psychological Impairment
Comprehension
Speech
Toileting
Eating
Dressing
Sense of Direction
Food Preparation
Maladaptive Behavior
Educational Skill Variables
Writing Skills
Reading Skills
Number Skills
Vocational/Avocational Skill Variables
Social Behavior
Money Handling
Telephone
Purchasing
Work Fitness
Paycheck
Hours Working
Job Satisfaction
Been Imprisoned
Has Voted
Other Demographic Variables to be Similarly Analyzed
Type of Admission
Time in Institution
Ehtnicity
Sex
Marital Status
Ambulation
Convulsive
Seizure
IQ
Level of Retardation
Other Life Skills Variables
Problem Finding Residence
Living Arrangement
Number Persons in Home
Does Own Laundry
Prepares Meals
Shops for Groceries
Shops for Clothing
Controls Spending
Housekeeping
Other Problems
Finding Same Sex Friend
Finding Op. Sex Friend
Keeping House Clean
Buying Food
Dooking Meals
Getting Along With Others
With Sickness
Fixing Things
Times to Church
Has Friends Over
Visited Friends
Visited Clubs
Problem Finding Fun
Times to Movie
Times to Restaurant
Problem Finding a Job
Problem Obeying a Boss
Problem Getting Places
Problem Budgeting Money
Problem Budgeting Time

$$Y=cC+a_1A+a_2A_2+a_3A_3+a_4A_4+a_5A_5+a_6A_6+i_1I_1+i_2I_2+\ldots+p_1P_1+\ldots p_nP_n+c_1C_1+\ldots c_nC_n+\ldots+w_1W_1+\ldots w_nW_n+\ldots n_1N_1+\ldots n_nN_n+s_1S_1+\ldots$$

VARIABLES	FOR ALL AGE GROUPS TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
TYPE OF ADMISSION						
Court Order	112	60	52	8	5	3
Voluntary	287	201	86	14	13	1
Transfer	78	50	28	14	9	5
Other	16	12	4			
Missing	4	2	2			
TIME IN INSTITUTION						
0	36	25	11			
1	94	71	23	5	3	2
2, 3	103	70	33	2	1	1
4, 5	75	46	29	5	5	
6-8	99	55	44	8	6	2
over 9	79	49	30	16	12	4
Missing	11	9	2			
ETHNICITY						
Anglo	297	211	86	30	24	6
Mexican American	96	52	44	1	1	
Negro	102	61	41	4	2	2
Missing	2	1	1	1		1
SEX						
Female	219	137	82	13	9	4
Male	278	188	90	23	18	5
MARITAL						
Never married	423	276	147	31	23	8
Separated	4	3	1			
Divorced	3	2	1			
Married	18	10	8	1		1
Widowed	2	2		1	1	
Missing	47	32	15	3	3	

	FOR ALL AGE GROUPS			AGES 35 TO 44		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
AMBULATION						
Unable to walk	11	2	9			
Walks unstably	17	4	13	1		1
Walks only with help	1	1				
Walks with no difficulty	152	103	49	14	13	1
Walks OK, climbs stairs	25	12	13	2	1	1
Runs with no difficulty	285	198	87	19	13	6
Missing	6	5	1			
CONVULSIVE DISORDERS						
None	425	288	137	32	24	8
Major motor seizures	23	9	14	2	1	1
Petit mal seizures	11	5	6			
Mixed	3	3				
Myoclonic seizures	1		1			
Other and unclassified	19	15	4	2	2	
Missing	15	5	10			
SEIZURE FREQUENCY						
None	420	288	132	32	24	8
Less than 1/year	3		3			
1-6 per year	12	7	5			
7-12 per year	3		3			
More than 12/year	5	4	1	1	1	
More than 1/day	9	4	5			
Formerly but not now	24	14	10	2	2	
Missing	21	8	13	1		1
LEVEL OF RETARDATION, IQ						
70 and above	127	123	4	8	8	
60-69	143	133	10	11	9	2
50-59	100	51	49	5	5	
40-49	61	11	50	9	4	5
Less than 40	66	7	59	3	1	2

VARIABLES	For All Age Groups			Ages 35 to 44		
	TOTAL	FQ	EQ	TOTAL	FQ	EQ
LEVEL OF RETARDATION, ABC						
Borderline and above	152	147	5	6	5	1
Mild	168	133	35	16	14	2
Moderate	116	32	84	9	6	3
Severe	50	10	40	5	2	3
Profound	9	1	8			
Missing	2	2				
PSYCHOLOGICAL IMPAIRMENT						
None	376	242	134	25	19	6
Neurosis	23	19	4	4	3	1
Psychosis	11	7	4	1		1
Character Disorder	34	26	8	3	3	
Psychophysiologic Disorder	4	4		1	1	
Other	17	12	5	1		1
Missing	32	15	17	1	1	
COMPREHENSION SKILLS						
Doesn't understand gestures	5		5			
Understands gestures	12	5	7			
Words or phrases	14	5	9			
Simple verbal communication	199	121	78	12	9	3
Complex verbal communication	252	188	64	24	18	6
Missing	15	6	9			
SPEECH DEVELOPMENT						
Missing	15	10	5			
Doesn't communicate at all	9	1	8			
Uses gestures	12	5	7			
Uses names of common objects	7		7			
Uses short phrases	36	13	23	1		1
Short sentences	221	142	79	15	12	3
Complex verbal concepts	197	154	43	20	15	5

VARIABLES	FOR ALL AGE GROUPS TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
WRITING SKILLS						
Missing	38	27	11	3		3
None	58	15	43	2	1	1
Scribbles	34	8	26	4	2	2
Copies	36	17	19	1	1	
Single words	59	35	24	6	5	1
Simple sentences	75	55	20	4	3	1
Messages	40	31	9	3	2	1
Letters	157	137	20	13	13	
TOILET SKILLS						
Missing	10	6	4			
Not trained	7		7			
Partially trained	5	1	4			
Needs help	6	2	4			
Occasional accidents	8	3	5			
Trained	461	313	148	36	27	9
EATING SKILLS						
Missing	10	5	5	1	1	
Must be fed	4		4			
Fingers	4	1	3			
Spoon	21	4	17			
Spoon and fork	148	80	68	6	4	2
Uses knife	310	235	75	29	22	7
DRESSING SKILLS						
Missing	8	2	6			
Doesn't cooperate	4		4			
Cooperates	12	3	9			
Partially	10	2	8			
Completely except for shoes	23	7	16	1		1
Completely	218	139	79	16	14	2
Appropriate clothes	222	172	50	19	13	6

VARIABLES	FOR ALL AGES TOTAL	FOR ALL AGES FQ	FOR ALL AGES EQ	AGES 35 TO 44 TOTAL	AGES 35 TO 44 FQ	AGES 35 TO 44 EQ
SENSE OF DIRECTION						
Missing	40	25	15	2	1	1
Non-ambulatory	13	3	10			
Lost	8	1	7			
Walk around cottage	41	13	28			
Few blocks	142	79	63	12	6	6
Bus	225	177	48	21	19	2
Reads map	28	27	1	1	1	
READING SKILLS						
Missing	54	31	23	4	1	3
Not recognize letters	68	10	58	4	1	3
Reads letters	14	5	9	2	2	
Reads name	31	15	16	2	2	
Simple words	94	59	35	8	6	2
Common signs	99	82	17	6	6	
Comics	64	57	7	2	1	1
Newspaper	73	66	7	8	8	
NUMBER CONCEPTS						
Missing	71	39	32	6	3	3
Can't count	62	15	47	3	2	1
To 10	45	21	24	3		3
10 objects	72	42	30	4	4	
100 objects	69	57	12	5	5	
Simple addition & subtraction	113	97	16	12	11	1
2 digit problems	48	38	10	2	1	1
Division	17	16	1	1	1	
SOCIAL BEHAVIOR						
Missing	38	22	16	4	3	1
Unresponsive	74	48	26	3	1	2
Imitative	22	11	11			
Cooperative, short periods	92	50	42	6	5	1
Competitive games	271	194	77	23	18	5

VARIABLES	FOR ALL AGES TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
MONEY HANDLING						
Missing	83	43	40	8	4	4
No idea	67	20	47	2		2
Value, but not use	49	29	20	1	1	
Uses, not correct change	71	45	26	7	5	2
Add to $1	53	42	11	3	3	
Makes change	149	127	22	14	13	1
Checking account	25	19	6	1	1	
TELEPHONE						
Missing	94	59	35	9	6	3
Cannot dial	107	35	72	5	2	3
Dial if given number	159	112	47	11	10	1
Find number and dial alone	137	119	18	11	9	2
PURCHASING SKILLS						
Missing	106	66	40	10	8	2
No shopping	93	32	61	4	2	2
Shop with supervision	36	19	17	1	1	
Minimal supervision	38	32	6	2	2	
Minor purchases alone	103	75	28	8	5	3
Own clothing accessories	39	28	11	3	1	2
All own clothing	82	73	9	8	8	
FOOD PREPARATION						
Missing	104	72	32	11	10	1
No food	94	36	58	4	2	2
Simple foods	99	66	33	4	2	2
Mixes and cooks simple foods	136	99	37	14	10	4
Cooks adequate meals	64	52	12	3	3	

	FOR ALL AGES			AGES 35 TO 44		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
WORK FITNESS						
Missing	32	18	14	3	2	1
No chores	31	8	23	1		1
Simple chores	94	53	41	3	3	
Routine tasks	168	108	60	15	10	5
Tools, little supervision	171	138	33	13	12	1
MALADAPTIVE BEHAVIOR						
None	134	79	55	10	5	5
Hyperactive	32	19	13	1	1	
Socially unacceptable	67	47	20	7	6	1
Withdrawn	61	43	18	7	6	1
Several	140	95	45	6	5	1
Other	40	28	12	3	2	1
Missing	23	14	9	2	2	
PAYCHECK (WEEKLY)						
Over $125		2			1	
$75 to $125		14			1	
$40 to $75		29			5	
$20 to $40		21			5	
$10 to $20		6			1	
Under $10		253			19	
HOURS WORKING						
None		14			1	
1 to 10		6				
11 to 20		8			1	
21 to 30		6				
31 to 40		43			3	
Over 40		18			5	
Not pertinent		29				
Missing		201			17	

VARIABLES	FOR ALL AGES TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
JOB SATISFACTION						
Missing		190			15	
Happy		66			8	
Not happy		2				
Sometimes yes, sometimes no		18			3	
Not pertinent		49			1	
LIVING ARRANGEMENT						
Boarding house		20	5		4	1
Apartment		15	4		2	
Parents		76	68		3	3
With friends		6	1		1	1
In own house		6	2			
Rents home		9	3		1	
Nursing home		3				
Institution or colony		1				
Missing		189	89		16	4
NUMBER OF PERSONS IN HOME						
0		8	2		1	
1		13	1		1	
2		23	2		1	
3		18	1		1	
4		7	2			1
5		6	1		2	
6		5				
7		1				
8		4	3			
9		16	55		2	2
Missing		224	105		19	6
HAS BEEN IMPRISONED						
Yes		20			3	
No		115			9	
Missing		190			15	

	FOR ALL AGES			AGES 35 TO 44		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
HAS VOTED						
Yes		20			1	
No		116			10	
Missing		189			16	
DOES OWN LAUNDRY						
Yes		94			10	
No		45			2	
Missing		186			15	
CONTROLS SPENDING (For EQ, Makes small purchases)						
Yes		118	62		12	5
No		19	16			
Missing		188	94		15	4
PREPARES MEALS (For EQ, prepares simple foods)						
Yes		85	61		8	5
No		53	17		4	
Missing		187	94		15	4
SHOPS FOR GROCERIES						
Yes		86			9	
No		50			3	
Missing		189			15	
SHOPS FOR CLOTHING						
Yes		119			11	
No		20			1	
Missing		186			15	
HOUSEKEEPING (For EQ, keeps house)						
Yes		125	58		11	4
No		13	17		1	1
Missing		187	97		15	4

	FOR ALL AGES			AGES 35 TO 44		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
TIMES TO CHURCH						
0		59	19		6	2
1		6	8			
2		13	7			
3		7	7		2	
4		19	27			2
5 or more		31	9		3	1
Missing		190	95		16	4
TIMES TO MOVIE						
0		67	46		8	1
1		19	11		2	1
2		14	14		1	
3		8	5			2
4		12	2		1	1
5 or more		16				
Missing		189	94		15	4
TIMES TO RESTAURANT						
0		38	37		4	1
1		19	9		2	
2		18	11			2
3		19	11		3	2
4		12	4		1	
5 or more		31	7		2	
Missing		188	93		15	4
HAD FRIENDS OVER						
0		41	31		5	2
1		7	40		1	2
2		8	1		1	
3		16			1	
4		16	1		3	
5 or more		47	3		1	1
Missing		190	96		15	4

VARIABLES	FOR ALL AGES TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
VISITED FRIENDS						
0		31	33		4	3
1		14	42		3	1
2		22	1			
3		9			1	
4		17	1		2	
5 or more		44	3		1	1
Missing		188	92		16	4
VISITED CLUBS						
0		114	71		11	5
1		5	3			
2		2	2		1	
3		3				
4		5				
5 or more		5				
Missing		191	96		15	4
PROBLEM FINDING RESIDENCE						
Yes		30			6	
No		104			5	
Missing		191			16	
PROBLEM FINDING A JOB (For EQ, prob. finding employment)						
Yes		48	30		3	3
No		86	33		8	1
Missing		191	109		16	5
PROBLEM OBEYING BOSS						
Yes		29			2	
No		101			9	
Missing		195			16	

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VARIABLES	FOR ALL AGES TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
PROBLEM FINDING FUN (For EQ, prob. with social activities)						
Yes		44	22		5	1
No		91	41		7	1
Missing		190	109		15	7
PROBLEM FINDING SAME SEX FRIENDS						
Yes		31	18		2	1
No		103	43		10	1
Missing		191	111		15	7
PROBLEM FINDING OPPOSITE SEX						
Yes		37			4	
No		97			7	
Missing		191			16	
PROBLEM GETTING TO PLACES (For EQ, prob. getting around)						
Yes		39	5		5	
No		97	44		7	1
Missing		189	123		15	8
PROBLEM BUDGETING MONEY (For EQ, prob. handling money)						
Yes		55	33		4	2
No		79	36		7	1
Missing		191	103		16	6
PROBLEM KEEPING HOUSE CLEAN						
Yes		30			6	
No		104			6	
Missing		191			15	
PROBLEM BUYING FOOD						
Yes		17			2	
No		115			9	
Missing		193			16	

VARIABLES	FOR ALL AGES TOTAL	FQ	EQ	AGES 35 TO 44 TOTAL	FQ	EQ
PROBLEM COOKING MEALS						
Yes		24			3	
No		108			8	
Missing		193			16	
PROBLEM BUDGETING TIME						
Yes		45			4	
No		91			8	
Missing		189			15	
PROBLEM GETTING ALONG WITH OTHERS						
Yes		39			3	
No		95			8	
Missing		191			16	
PROBLEM WITH SICKNESS						
Yes		32			5	
No		102			6	
Missing		191			16	
PROBLEM FIXING BROKEN THINGS						
Yes		30			4	
No		102			7	
Missing		193			16	

VARIABLES	AGE 45 TO 54 TOTAL	FQ	EQ	AGES OVER 65 TOTAL	FQ	EQ
TYPE OF ADMISSION						
Court order	7	2	5	4	2	2
Voluntary	2	2	1	4	2	2
Transfer	3	1	1	3	1	2
LENGTH OF INSTITUTIONAL STAY						
0				1	1	
1	1		1	3	2	1
2, 3				1		1
6-8	5	2	3	2		2
Over 9	5	2	3	4	2	2
Missing	1	1				
ETHNICITY						
Anglo	8	4	4	7	4	3
Mexican American	2		2	2		2
Negro	2	1	1	1		1
Missing				1	1	
SEX						
Female	9	2	7	5	3	2
Male	3	3		6	2	4
MARITAL						
Never married	10	5	5	8	3	5
Married	2		2			
Missing				3	2	1
AMBULATION						
Unable to walk	1		1	1		1
Walks unstably				1		1
Walks with no difficulty	4	2	2	2	2	
Walks OK and climbs stairs				1		1
Runs with no difficulty	7	3	4	6	3	3

VARIABLES	AGE 45 TO 54 TOTAL	FQ	EQ	OVER 65 TOTAL	FQ	EQ
CONVULSIVE DISORDERS						
None	10	5	5	9	5	4
Major motor seizures				1		1
Other and unclassified	1		1	1		1
Missing	1		1			
SEIZURE FREQUENCY						
None	9	5	4	8	5	3
1 to 6 per year	1		1	1		1
Formerly but not now	1		1			
Missing	1		1	2		2
LEVEL OF RETARDATION, IQ						
Over 70	1	1		3	3	
60 to 69	2	1	1	2	1	1
50 to 59	1	1		1	1	
40 to 49	4	2	2	2		2
Less than 40	4		4	2		3
LEVEL OF RETARDATION, ABC						
Borderline and above	1	1		3	3	
Mild	5	2	3	2	1	1
Moderate	2	1	1	5	1	4
Severe	3	1	2	1		1
Profound	1		1			
PSYCHOLOGICAL IMPAIRMENT						
None	10	4	6	7	3	4
Psychosis	1	1		2	1	1
Character Disorder				2	1	1
Missing	1		1			
COMPREHENSION SKILLS						
Doesn't understand gestures				1		1
Simple verbal communication	5	2	3	5	2	3
Complex verbal communication	7	3	4	5	3	2

	AGE 45 TO 54			OVER 65		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
SPEECH DEVELOPMENT						
Missing				1	1	
Doesn't communicate w/ words or gestures	1		1			
Uses gestures				1		1
Uses names of common objects	1		1			
Short sentences	4	2	2	6	2	4
Complex verbal concepts	6	3	3	3	2	1
WRITING SKILLS						
Missing	2	1	1			
None	3		3	3		3
Scribbles	1	1				
Copies	1	1		1	1	
Single words	1		1			
Simple sentences	2	2		2		2
Messages				1	1	
Letters	2		2	4	3	1
TOILET SKILLS						
Missing	1	1				
Not trained				1		1
Partially	1		1			
Trained	10	4	6	10	5	5
EATING SKILLS						
Missing				1	1	
Spoon	1		1	1		1
Spoon and fork	3	1	2	1		1
Uses knife	8	4	4	8	4	4
DRESSING SKILLS						
Cooperates	2		2	1		1
Completely	4	2	2	4	2	2
Appropriate clothes	6	3	3	6	3	3

VARIABLES	AGE 45 TO 54			OVER 65		
	TOTAL	FQ	EQ	TOTAL	FQ	EQ
SENSE OF DIRECTION						
Missing	1	1				
Non-ambulatory	1		1			
Lost				1		1
Walk around cottage	1		1	2	1	1
Few blocks	3		3	2	1	1
Bus	6	4	2	5	2	3
Reads map				1	1	
READING SKILLS						
Missing	2	1	1			
Not recognize letters	5	1	4	3		3
Reads name				1	1	
Simple words	1	1		1		1
Common signs	1	1		3	1	2
Comics	2	1	1	1	1	
Newspaper	1		1	2	2	
NUMBER CONCEPTS						
Missing	3	1	2	1	1	
Can't count	5	1	4	4	1	3
To 10	1	1				
100 objects				1		1
Simple addition and subtraction	3	2	1	4	3	1
2-digit problems				1		1
SOCIAL BEHAVIOR						
Missing	1		1	2	2	
Unresponsive	1		1	2		2
Imitative	1		1			
Cooperative, short periods	2	2		1	1	
Competitive games	7	3	4	6	2	4

	AGE 45 TO 54			OVER 65		
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
MONEY HANDLING						
Missing	4	1	3	2	1	1
No idea	4	1	3	3	1	2
Value, not use	1	1				
Uses, not correct change				1	1	
Makes change	2	1	1	2	1	1
Checking account	1	1		3	1	2
TELEPHONE						
Missing	4	1	3	1	1	
Cannot dial	4	1	3	4	1	3
Dial if given number	3	3		1		1
Find number and dial alone	1		1	5	3	2
PURCHASING SKILLS						
Missing	3		3	1	1	
No shopping	4	1	3	4	1	3
Minimal supervision				2	2	
Minor purchases alone	2	2		1		1
Own clothing accessories				2		2
All own clothing	3	2	1	1	1	
FOOD PREPARATION						
Missing	1		1			
No food	4	1	3	3		3
Simple food	2	1	1	1		1
Mixes and cooks simple foods	2	1	1	2	1	1
Cooks adequate meals	3	2	1	5	4	1
WORK FITNESS						
No chores	1		1	3		3
Simple chores	1		1	2	1	1
Routine tasks	6	2	4	2	2	
Tools, little supervision	4	3	1	4	2	2

VARIABLES	AGE 45 TO 54 TOTAL	FQ	EQ	AGES OVER 65 TOTAL	FQ	EQ
MALADAPTIVE BEHAVIOR						
None	5	2	3	2		2
Socially unacceptable	2	1	1	2	2	
Several	2		2	5	2	3
Withdrawn	3	2	1			
Other				1		1
Missing				1	1	
PAYCHECK (WEEKLY)						
$40 to $74		1				
$20 to $39		1				
Under $10		3			5	
HOURS WORKING						
31 to 40		1				
Over 40		1				
Not pertinent					1	
Missing		3			4	
JOB SATISFACTION						
Missing		3			3	
Happy		2				
Not pertinent					2	
LIVING ARRANGEMENT						
Boarding house		1				
Apartment					1	1
With parents			3			2
With friends		1				
In own house			1			
Nursing home					1	
Missing		3	3		3	3

VARIABLES	TOTAL	AGE 45 TO 54 FQ	EQ	TOTAL	OVER 65 FQ	EQ
NUMBER OF PERSONS IN HOME						
1					2	
2			1			
3						1
9		1	2			2
Missing		4	4		3	3
HAS BEEN IN PRISON						
No		2			2	
Missing		3			3	
HAS VOTED						
No		2			2	
Missing		3			3	
DOES OWN LAUNDRY						
Yes		2			1	
No					1	
Missing		3			3	
CONTROLS SPENDING (For EQ, makes small purchases)						
Yes		2	2		2	2
No			1			1
Missing		3	4		3	3
PREPARES MEALS (For EQ, prepares simple foods)						
Yes		2	1		1	2
No			2		1	1
Missing		3	4		3	3

VARIABLES	TOTAL	AGES 45 TO 54 FQ	EQ	TOTAL	OVER 65 FQ	EQ
SHOPS FOR GROCERIES						
Yes		2			2	
Missing		3			3	
HOUSEKEEPING (For EQ, keeps house)						
Yes		2	1		2	1
No			2			2
Missing		3	4		3	3
SHOPS FOR CLOTHING						
Yes		2			2	
Missing		3			3	
TIMES TO CHURCH						
0		2			1	
1			1			
2						1
4			3			2
5 or more					1	
Missing		3	3		3	3
TIMES TO MOVIE						
0		1	4			
1						1
2		1			2	1
Missing		3	3		3	4
TIMES TO RESTAURANT						
0			2		1	
1			1		1	
2			1			1
4		2				1
5 or more						1
Missing		3	3		3	3

VARIABLES	TOTAL	AGES 45 TO 54 FQ	EQ	TOTAL	OVER 65 FQ	EQ
HAD FRIENDS OVER						
0			1			1
1			2			1
2		1				
3					1	
4		1				
5 or more					1	
Missing		3	4		3	4
VISITED FRIENDS						
0			1		1	
1			3			2
2		2				
4						4
5 or more					1	
Missing		3	3		3	
VISITED CLUBS						
0		2	4		2	2
Missing		3	3		3	4
PROBLEM FINDING RESIDENCE						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM FINDING A JOB (For EQ, prob. finding employment)						
Yes		1				
No		1	3		1	3
Missing		3	4		4	3

VARIABLES	TOTAL	AGE 45 TO 54 FQ	EQ	TOTAL	OVER 65 FQ	EQ
PROBLEM FOLLOWING BOSS'S INSTRUCTIONS						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM FINDING FUN (For EQ, prob. with social activities)						
Yes		1				
No		1	3		1	3
Missing		3	4		4	3
PROBLEM FINDING SAME SEX FRIENDS						
Yes		1				1
No		1	3		1	2
Missing		3	4		4	3
PROBLEM FINDING OPPOSITE SEX FRIENDS						
Yes		2				
No					1	
Missing		3			4	
PROBLEM GETTING TO PLACES (For EQ, prob. getting around)						
Yes		1	1			
No		1	2		1	3
Missing		3	4		4	3
PROBLEM BUDGETING MONEY (For EQ, prob. handling money)						
Yes		1	1			2
No		1	3		1	1
Missing		3	3		4	3

		AGES 45 TO 54			OVER 65	
VARIABLES	TOTAL	FQ	EQ	TOTAL	FQ	EQ
PROBLEM KEEPING HOUSE CLEAN						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM BUYING FOOD						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM COOKING MEALS						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM BUDGETING TIME						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM GETTING ALONG WITH OTHERS						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM WITH SICKNESS						
Yes		1				
No		1			1	
Missing		3			4	
PROBLEM FIXING BROKEN THINGS						
Yes						
No		2			1	
Missing		3			4	

APPENDIX F

Additional Data

APPENDIX F.1

Prevalence Mental Retardates in Texas Community Programs by Adaptive Behavior Level and Age Groups

	AGE GROUP					
ADAPTIVE BEHAVIOR LEVEL	35-54		55+		TOTAL	
	ADMISSIONS	INACTIVATIONS	ADMISSIONS	INACTIVATIONS	ADMISSIONS	INACTIVATIONS
NO RETARDATION	9	6	1	1	10	7
MILD	88	66	20	16	108	82
MODERATE	69	62	10	9	79	71
SEVERE	30	29	7	6	37	35
PROFOUND	15	11	6	0	21	11
NOT REPORTED	316	229	69	63	385	292
TOTALS	527	403	113	95	640	498

FY 1975

APPENDIX F.2

Mental Retardates in Texas Community Programs
Type of Inactivation by Age Group

	AGE GROUPS		
	35-54	55+	TOTALS
TYPE OF INACTIVATION			
PERSON WITHDREW	191	42	233
DISCHARGED WITH REFERRAL	121	32	153
DISCHARGED WITHOUT REFERRAL	91	21	112
TOTALS	403	95	498

FY 1975

APPENDIX F.3

Mental Retardates[a] at Discharge from State Hospitals
Primary Psychiatric Diagnosis by Length of Stay by Age Group

LENGTH OF STAY	TOTAL			30 DAYS OR LESS		31-90 DAYS		91-65 DAYS		1-5 YEARS		OVER 5 YEARS	
AGES	0-35	35-54	55+	35-54	55+	35-54	55+	35-54	55+	35-54	55+	35-54	55+
DIAGNOSIS													
SCHIZOPHRENIA	120	74	9	14	0	22	0	13	2	14	1	11	16
OTHER FUNCTIONAL PSYCHOSIS	5	2	1	1	1	0	0	0	0	0	0	1	0
PSYCHOTIC OBS	19	15	14	3	0	3	2	1	1	3	0	5	11
NON-PSYCHOTIC OBS	20	13	22	3	1	2	0	0	2	2	2	6	17
NEUROSIS	15	6	2	2	1	4	1	0	0	0	0	0	0
ALCOHOLISM	7	17	4	4	0	12	4	1	0	0	0	0	0
DRUG ABUSE	6	0	1	0	0	0	1	0	0	0	0	0	0
PERS., TRANS., BEHAV., ETC.	47	7	0	2	0	0	0	2	0	1	0	2	0
MENTAL RETARD.	439	150	102	18	6	29	13	29	9	23	18	51	56
NONE	0	0	0	0	0	0	0	0	0	0	0	0	0
NOT REPORTED	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	678	284	155	47	9	72	21	46	14	43	21	76	90

a. Primary, secondary or tertiary diagnosis

FY 1975

APPENDIX G

Mentally Retarded Persons Served by TDMHMR: Number Entering From and Discharged to Each County.

The total population figure is also given to indicate the size of county in terms of numbers of persons residing in the county.

APPENDIX G

TDMHMR
Central Offices
Support Services

Mentally Retarded Persons Served By TDMHMR: Number Entering From and Discharged to Each County, and Total County Population, FY 1975

	TOTAL: AGE 35 AND OLDER				AGE 35-54							AGE 55 AND OLDER						
						Community			Institutions				Community			Institutions		
COUNTY	Population	Served	Activations	Inactivations	Population	Served	Activation	Inactivations	Served	Activations	Inactivations	Population	Served	Activations	Inactivations	Served	Activations	Inactivations
Anderson	14,1	17	2	2	6,0		1		9			8,1	1	1	1	7		1
Andrews	4,9	1			3,3				1			1,6						
Angelina	22,0	55	7	7	11,2	3	5	4	32	2	2	10,8				20		1
Aransas	4,8	4			2,2				4			2,6						
Archer	2,9	3			1,3				2			1,6				1		
Armstrong	1,0	2			0,4				1			0,6				1		
Atascosa	8,1	8	1	2	3,9			1	4			4,2		1		4		1
Austin	7,5	7	1	1	2,9					1	1	4,6				3		
Bailey	3,7	8	1	1	2,0				5	1	1	1,7				3		
Bandera	2,7	1		2	1,1			1	1		1	1,6				0		
Bastrop	8,7	21	4	8	3,5	2			14	3	2	5,2	2	1		3		6

*These numbers are read in 1,000's, i.e. 14,1 = 14,100.

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Baylor	2,8	2	1		1,1							1,7				2	1	
Bee	8,2	12			4,3	1			6			3,9				5		
Bell	40,1	43	1	6	22,9	7	1	3	23		3	17,2	1			12		
Bexar	326,6	308	16	72	192,7	36	5	13	190	9	27	133,9	4	1	1	78	1	31
Blanco	2,0	2			0,8				1			1,2				1		
Borden	0,4				0,2							0,2						
Bosque	6,4	19	2	3	2,1				9		1	4,3	3	2	2	7		
Bowie	31,1	30	4	2	15,9	1	1		20	2	2	15,2	1	1		8		
Brazoria	45,7	35	5	15	30,0	12	3	2	17	1	5	15.7	1	1		5		8
Brazos	19,4	29	7	2	10,4	10	6		9		1	9,0	2	1	1	8		
Brewster	2,6	3	1		1,3				3	1		1,3						
Briscoe	1,3	3			0,6	1						0,7				2		
Brooks	3,1	5			1,7				3			1,4	1			1		
Brown	13,1	38	2	1	5,1	7	1		19			8,0	1	1	1	11		
Burleson	5,0	7	1		2,0				5			3,0	1	1		1		
Burnet	6,5	12	2	1	2,3	4	1		6	1	1	4,2	1			1		
Caldwell	8,4	11		3	3,7	2			7		1	4,7				2		2
Calhoun	7,2	7	1	1	4,7	1	1	1	4			2,5				2		

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Callahan	4,5	11			1,7				5			2,8				6		
Cameron	53,8	51	2	3	29,3	8	2	3	26			24,5				17		
Camp	4,0	4			1,8				2			2,2				2		
Carson	2,9				1,5							6,4						
Cass	11,7	22	6	4	5,2	1	2		14	1	2	6.5	1	1		6	2	2
Castro	4,0	2		1	2,5			1				1,5				2		
Chambers	5,5	9	3	2	3,3	4	1	1	4	1	1	2,2	1	1				
Cherokee	16,5	55	7	20	7,0	4	2	3	30	3	11	9,5	3	1	2	18	1	4
Childress	3,5	11	2	1	1,3	3	2		5			2,2				3		1
Clay	4,2	5		1	1,8				1		1	2,4				4		
Cochran	2,2	5			1,2				3			1,0				2		
Coke	1,6	4			0,7				1			0,9				3		
Coleman	5,8	7		1	2,0	1			4			3,8				2		
Collin	27,8	33	2	4	14,7				27	2	4	13,1				6		
Collingsworth	2,5	3		1	1,0			1	2			1,5				1		
Colorado	8,6	14	2	5	3,9	2		1	8	1	3	4,7				4	1	1
Comal	11,7	10			5,8				7			5,9				3		
Comanche	6,6	26	3	1	2,4	6	3	1	12			4,2				8		

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Concho	1,6	3			0,6				2			1,0				1		
Cooke	11,1	22	3	2	5,3	5	3		8			5,8				9		2
Coryell	9,9	9			5,2				5			4,7				4		
Cottle	1,6	3	1	1	0,7				2	1	1	0,9				1		
Crane	1,8	2		1	1,1	1		1	1			0,7						
Crockett	1,7	2			1,0				2			0,7						
Crosby	3,9	4			1,9				3			2,0				1		
Culberson	1,3				0,8							0,5						
Dallam	2,7	6		2	1,3	1		2	1			1,4				4		
Dallas	559,0	564	105	167	346,2	79	62	91	321	33	51	212,8	15	5	15	149	5	10
Dawson	7,1	9		4	3,6			2	6		1	3,5				3		1
Deaf Smith	7,4	5	1	1	4,4	1	1		3		1	3,0				1		
Delta	2,7	7		1	0,8				4			1,9				3		1
Denton	28,4	33	2	6	15,6	3	1	1	21	1	3	12,8				9		2
Dewitt	9,7	11		1	3,9				9			5,8				2		1
Dickens	2,0	5			0,7				2			1,3				3		
Dimmit	3,3	5		2	1,7				5		1	1,6						1
Donley	1,9	7	1	1	0,7	1	1	1	2			1,2				4		
Duval	5,0	8	1		2,5	3	1		2			2,5				3		

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Eastland	9,8	28		2	3,4				15			6,4				13		2
Ector	39,7	30	6	5	26,7	7	5	2	17		1	13,0			1	6	1	1
Edwards	1,0				0,5							0,5						
Ellis	21,4	41	4	5	9,8	5	2	3	16			11,6	2	2	1	18		1
El Paso	133,8	113	23	11	86,5	27	13	8	59	5	2	47,3	2	5	1	25		
Erath	9,2	13	1	1	3,3	1	1		5		1	5,9	1			6		
Falls	9,0	21	1	2	3,3	1		1	14			5,7	1	1	1	5		
Fannin	12,2	16	4	4	4,6	2	2	1	6	2	3	7,6				8		
Fayett	10,1	17			3,7	5			8			6,4				4		
Fisher	3,2	7		1	1,3				4		1	1,9				3		
Floyd	5,0	10		3	2,5			2	4		1	2,5				6		
Foard	1,3	3			0,5				3			0,8						
Fort Bend	20,7	25	5	1	12,0	3	3	1	16	1		8,7	1	1		5		
Franklin	2,8	5			1,1				3			1,7				2		
Freestone	6,0	11	3	5	2,1				8	2	1	3,9				3	1	4
Frio	4,4	6			2,2	1			5			2,2						

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Gaines	4,8	10		2	2,8			1	6			2,0	1		1	3		
Galveston	75,8	59	9	1	44,8	5	5		34	2	1	31,0	1	2		19		
Garza	2,4	5			1,2				5			1,2						
Gillespie	5,6	11	1	2	2,3	1	1	1	6		1	3,3				4		
Glasscock	0,5				0,3							0,2						
Goliad	2,4	5	1		1,1	2	1		1			1,3				2		
Gonzales	8,0	25	5	4	3,3	8	2		4	2	3	4,7		1		13		1
Gray	13,0	16	8	4	6,8	6	7	3	3			6,2				7	1	1
Grayson	38,7	62	7	9	18,5	8	4	4	33	1	2	20,2	2	2	2	18		1
Gregg	34,5	50	7	12	18,4	6	3	5	37	2	4	16,1	1	1	2	6	1	1
Grimes	5,8	14	1		2,2	2	1		6			3,6				6		
Guadalupe	15,0	23	2	2	7,4	4	1		7	1	1	7,6	4		1	8		
Hale	14,6	26	7	5	7,8	4	5	5	9			6,8	1	1		12	1	
Hall	3,0	4			1,2			2	3		1,8					1		
Hamilton	4,3	10	2		1,4	1	1		5			2,9				4	1	
Hansford	2,7	1			1,7				1			1,0						
Hardman	3,6	14	7	3	1,4	4	5	1	6	2	2	2,2				4		

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Hardin	13,4	10			7,2				8			6,2				2		
Harris	723,8	514	61	50	462,0	61	39	19	312	14	16	261,8	13	6	7	128	2	8
Harrison	20,2	40	7	6	9,6	10	5	2	17		2	10,6	2	1	1	11	1	1
Hartley	1,4				0,7							0,7						
Haskell	4,5	12	6	2	1,9	6	6	2	4			2,6				2		
Hays	9,0	12	1	2	4,6	3	1	1	5			4,4	1			3		1
Hemphill	1,4	4	1	2	0,7	1	1	2	3			0,7						
Henderson	13,3	35	10	16	5,7	7	6	5	19	4	10	7,6				9		1
Hidalgo	65,9	56	6	13	37,0	9	4	3	36	1	7	28,9	2	1	1	9		2
Hill	12,1	28	4		4,6	1	1		12	1		7,5	1	2		14		
Hockley	8,1	8	1		4,4				5			3,7	1	1		2		
Hood	3,4	5			1,4				4			2,0				1		
Hopkins	10,4	24	2	2	4,3	1	1	1	10	1	1	6,1	1			12		
Houston	8,5	16	3	4	3,4	2	2	1	8	1	1	5,1	1		1	5		1
Howard	15,7	25	8	8	8,9	2	3		19	5	8	6,8				4		
Hudspeth	0,9	3			0,5				2			0,4				1		
Hunt	21,0	45	16	15	9,8	12	12	10	16	3	2	11,2				17	1	3
Hutchinson	11,7	11			6,7	1			5			5,0				5		

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Irion	0,5				0,2							0,3						
Jack	3,6				1,5				1			2,1				2		
Jackson	5,9		3	1	3,0	3	2			1	1	2,9						
Jasper	11,4		5	5	5,5	5	5	2				5,9						3
Jeff Davis	0,7				0,3							0,4						
Jefferson	108,9		21	28	62,5	25	11	13		8	9	46,4	10	2	3			3
Jim Hogg	2,0		1	1	1,0	2	1	1				1,0						
Jim Wells	13,1		4	3	7,4	5	2	2		1	1	5,7	1	1				
Johnson	21,7			2	10,8	2		1				10,9	1		1			
Jones	8,3		4	6	3,4		1				2	4,9	1	1			2	4
Karnes	6,0		3	7	2,9			1			1	3,1	1				3	5
Kaufman	16,0		5	15	7,1	1		1		3	6	8,9	1				2	8
Kendall	3,7				1,7	3						2,0						
Kenedy	0,2				0,1							0,1						
Kent	0,7				0,3							0,4						
Kerr	11,5		4	3	4,1					3	2	7,4			1		1	
Kimble	1,9		2		0,8		1			1		1,1	1					
King	0,2				0,1							0,1						

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Kinney	0,8	1			0,4				1			0,4						
Kleberg	9,9	10	6	4	5,7	7	5	3	2	1		4,2			1	1		
Knox	3,1	2		5	1,3				2			1,8						5
Lamar	17,4	9	2	3	7,4	1			3	1		10,0	1		2	4	1	1
Lamb	8,2	1			4,0	1						4,2						
Lampasas	4,6	6		1	2,0	1			4		1	2,6				1		
Lasalle	2,0	0			0,9							1,1						
Lavaca	9,6	4	2		3,6	3	2					6,0				1		
Lee	4,3	2	1		1,7				1	1		2,6	1					
Leon	4,7	3	1	2	1,7	1	1		1		1	3,0				1		1
Liberty	15,0	12		1	7,8	2			10		1	7,2						
Limestone	9,5	35		13	3,6	1		2	17		8	5,9				17		3
Lipscomb	1,8	1			0,9				1			0,9						
Live Oak	3,0	3	2	2	1,4	1	1		1	1	2	1,6				1		
Llano	4,5	9	2	1	1,4	2		1	3	1		3,1	2	1		2		
Loving	0,1											0,1						
Lubbock	66,3	29	9	7	39,8	12	3	3	12	3	1	26,5	4	2	3	1	1	
Lynn	3,9	3			2,0	1			2			1,9						

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
McCullock	4,6	4	2		1,7				2	1		2,9				2	1	
McLennan	68,6	62	12	39	34,3	34	6	20	17	1	11	34,3	4	4	6	7	1	2
McMullen	0,5				0,2							0,3						
Madison	3,5	1			1,3				1			2,2						
Marion	4,2	5		1	1,7				4			2,5				1		1
Martin	1,9	1	1		1,0	1	1					0,9						
Mason	1,8			1	0,7							1,1						1
Matagorda	12,5	18	5	3	6,7	7	2		10	3	3	5,8				1		
Maverick	6,6	2			3,9				1			2,7				1		
Medina	8,8	9		3	4,5	1			4		1	4,3				4		2
Menard	1,4	2		1	0,5	2						0,9			1			
Midland	31,0	11	7	10	21,0	6	5	7	3	1		10,0	2	1	2			1
Milam	10,3	3	3	1	4,2	2	2	1				6,1				1	1	
Mills	2,5	1		2	0,8				1		2	1,7						
Mitchel	4,4	5	3	7	1,9	4	2				1	2,5	1	1				6
Montague	8,3	7	3	5	3,3	3	2	2	1	1		5,0	1			2		3
Montgomery	23,2	6	3	2	13,3	1	1		5	2	2	9,9						
Moore	5,7	1		1	3,7	1		1	3			3,0						

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Morris	5,9	2			3,0				1			2,9				1		
Motley	1,1				0,4							0,7						
Nacogdoches	14,1	12	5	7	6,4	5	5	3	4		4	7,7				3		
Navarro	16,0	11	5	4	6,3	4	3	1	2			9,7	1	1		4	1	3
Newton	5,0	5	3	2	2,4	2	2	1	2	1	1	2,8				1		
Nolan	7,6	8	5	1	3,6	3	4		4	2	1	4,2	1					
Nueces	93,1	41	8	14	57,1	18	6	9	16	2	3	36,0	1		1	6		1
Ochiltree	4,3	5	2	2	2,7	1	1	1				1,6				4	1	1
Oldham	0,9				0,5							0,4						
Orange	29,1	13	7	7	18,5	8	7	7	4			10,6				1		
Palo Pinto	11,5	5	1	1	6,0		1	1	3			5,5				2		
Panola	7,8	7	1	4	3,4	1		1	5	1	3	4,4				1		
Parker	14,3	6	1	2	7,4		1		2		1	6,9			1	4		
Parmer	4,3	2			2,5							1,8				2		
Pecos	5,4	2	1	1	3,4	1	1	1	1			2,0						
Polk	7,0	6	1	4	3,0	1			4	1	3	4,0				2		1
Potter	40,8	19	6	8	21,8	10	3	5	7	2	2	19,0	1	1	1	1		
Presidio	2,1	1			1,0				1			1,1						

	P	S	A	I	P	S	A	I	S	A	I	P	S	A	I	S	A	I
Rains	2,0	3			0,8				2			1,2				1		
Randall	23,4	5	3		16,3	3	2					7,1	1	1		1		
Reagan	1,4	1			0,9							0,5				1		
Real	1,0				0,4							0,6						
Red River	7,3	5	1	1	2,7				2			4,6				3		
Reeves	6,2	1			3,8				1			2,4						
Refugio	4,2	4	1	1	2,2	1	1	1	3			2,0						
Roberts	0,4				0,2							0,2						
Robertson	7,1	4	1	1	2,7	2	1	1	1			4,4			1			
Rockwall	3,4				1,7							1,7						
Runnels	6,2	3			2,5				1			3,7				2		
Rusk	17,2	18	11	11	7,1	2	4	1	10	5	7	10,1	1	1		5	1	3
Sabine	3,5	2			1,5				1			2,0				1		
San Augustine	3,8	3	2	3	1,6		1		1		1	2,2				2	1	2
San Jacinto	3,2	2	1		1,2							2,0	1	1		1		
San Patricio	18,6	4	1	2	10,8	1			2	1		7,8	1					2
San Saba	3,0	4	2	2	1,1			1	3	1		1,9				1	1	1
Schleicher	1,1	2			0,5							0,6				2		
Scurry	7,3	6	1	3	3,8	5	1	2	1		1	3,5						

Shackelford	1,8	1		1	0,7				1		1	1,1					
Shelby	9,8	15	13	10	4,0	1	4	1	10	7	7	5,8	2	2	2	2		
Sherman	1,6				1,0							0,6						
Smith	44,5	32	20	19	22,9	10	14	7	14	3	6	21,6	4	2	2	4	1	4
Somervell	1,5				0,6							0,9						
Starr	6,7	1	1		3,6				1	1		3,1						
Stephens	4,5	1		1	1,8			1	1			2,7						
Sterling	0,4				0,2							0,2						
Stonewall	1,3	2	1		0,6	1	1		1			0,7						
Sutton	1,4	1			0,8				1			0,6						
Swisher	4,6	4	5	3	2,5	2	3	1	2	2	2	2,1						
Tarrant	307,7	85	45	17	187,8	39	32	6	26	1	4	119,9	10	10	5	10	2	2
Taylor	40,2	26	11	13	21,8	12	9	2	11	2	2	18,4			1	3		8
Terrell	0,8	1			0,4							0,4	1					
Terry	5,8	1			3,3				1			2,5						
Throckmorton	1,2				0,4							0,8						
Titus	8,5	1			3,7							4,8				1		
Tom Green	80,4	19	10	10	15,6	13	6	6	3	4	3	14,8				3		1

Travis	110,3	266	82	68	64,2	125	58	36	55	8	17	46,1	43	15	8	43	1	7
Trinity	3,9	3	3	2	1,4		1		2	2	2	2,5				1		
Tyler	6,2	5	2		2,6	1	1		3			3,6	1	1				
Upshur	10,1	3	2	2	4,4	1	1	1	2	1		5,6						1
Upton	2,0	2			1,2				2			0,8						
Uvalde	7,5	4	1	1	3,7				4	1	1	3,8						
Val Verde	9,5	1		1	5,8				1		1	3,7						
Van Zandt	11,8	11	2	4	4,8				8			7,0	1		1	2	2	3
Victoria	22,3	13	5	7	13,4	3	2	3	6	1	2	8.9	2	1	1	2	1	1
Walker	10,2	9		1	5,5	3			4			4,7	1			1		1
Waller	5,3	2	1	1	2,4				1	1	1	2,9				1		
Ward	5,4	7	3	1	3,2	2	1	1	4	1		2,2	1	1				
Washington	9,6	13	5		3,9	11	4		1		1	5,7				1		
Webb	25,5	12	4	4	14,1	6	2	2	5		1	11,4		2	1	1		
Wharton	16,0	18	4	4	7,9	5	3		9		1	8,1			2	4	1	1
Wheeler	3,4	3	3	1	1,3				2	1		2,1	1	1	1		1	
Wichita	50,8	54	23	31	28,0	22	15	6	15	3	10	22,8	4	5	2	13		13
Wilbarger	8,1	14	5	4	3,4	2	2	1	11	3	2	4,7				1		1
Willacy	5,7	3	1	1	3,0				2	1	1	2,7				1		
Williamson	17,8	16	8	3	7,7	3	3		4	1		10,1	2	3	1	5	1	2

Wilson	5,7	9	2		2,7	2	1		3			3,0	1	1		3		
Winkler	4,2	3	1	1	2,6	1	1		1			1,6				1		1
Wise	9,6	6	2	2	4,5		1	1	3			5,1	1	1		2		1
Wood	9,9	8	2	3	3,8	2	2		5		1	6,1				1		2
Yoakum	3,1	1			2,0				1			1,1						
Young	8,3	9	2		3,4				3			4,9	1	1		5	1	
Zapata	1,9	1			0,9	1						1,0						
Zavala	4,2	2		1	2,3				1			1,9			1	1		
County Unknown		9	1						6	1						3		
Not Reported/ Other		14	18	28		11	11	13		4	12		3	3	1			2
Out of State		27							21							6		

APPENDIX H

Personal Observations and Impressions

George M. Wawrykow, Ph.D.
Research Specialist
Project Director

APPENDIX H

APPENDIX H

PERSONAL OBSERVATIONS AND IMPRESSIONS

Planning for services for the mentally retarded in Texas is chiefly the responsibility of TDMHMR. The State Department of Mental Health and Mental Retardation has primary responsibility for service delivery to persons age 0-3 and to those age 18 and older. During the interim from ages 3-21, the responsibility for service provision lies with local independent school districts and the Texas Education Agency. Even during these years, however, TDMHMR plays an important role with families and cases requiring specialized services.

During the late collection phase of this study, visits were made to some of the state schools, human development and community centers. After interviewing persons in a cross section of disciplines and investigating programs, several impressions were noted.

A. Little programming specifically for middle aged or elderly mentally retarded persons was found. This in itself need not be bad, as such persons may, in fact, be assimilated into regular programs. Many older persons who have been institutionalized for a long time, however, do appear older than their chronological age, appear to have aged biologically more than persons of normal intelligence, and have a paucity of human, educational and vocational skills.

The two state schools in which programs for middle aged or elderly mentally retarded were specially designed are San Angelo State Center and Travis State School. Unfortunately, the lack of specific information on this population has meant that programming has been very limited in scope or nature.

B. During the visits it was not uncommon to see such persons sitting or walking alone, watching TV and being relatively unengaged in planned activities. Possible reasons for this may be:

1. mentally retarded persons who have been in institutions for much of their lifetime are exhibiting "institutional" behaviors,
2. with limited funding and resources, programs were geared toward younger residents with whom it was thought that less effort would be required to equip them with the skills for community placement or that investment of resources through day residency programs could prevent institutionalization,
3. until successes were established by including some persons age 35 or over in training programs designed for young people, the prognosis for the older mentally retarded was bleak.

C. Most programs for the mentally retarded exclude the middle aged and the elderly, albeit unintentionally, partially because the staff are untrained in providing for the special needs and abilities of this population. By including mentally retarded persons age 35 or older in programming aimed primarily at younger persons, it was found that they often regained productive work skills, were able to participate in sheltered workshops or hold jobs, and appeared younger.

D. Several exciting embryonic programs are underway but primarily involve persons under age 35 within TDMHMR facilities.

1. Assessment and individualized habilitation plans are based largely upon the Behavior Characteristics Progression Sequential (BCP). This instrument evaluates skills level in several dozen areas (strands) in a developmental sequence for diagnosis. The results of the assessment for each new client are discussed in a staff conference and objectives are targeted. The BCP focuses the attention of staff on specific needs and skills for habilitation and therefore should result in active habilitation rather than custodial care. The BCP is very detailed and extensive, so it is perceived as unwieldly by many. Unfortunately the BCP appears to be less useful with the older population as the special needs of the middle aged and elderly are not fully evaluated with this instrument.
2. Programs to increase the human skills for living are basic, and minimum skills are precursors to higher skills-training programs. Living skills include basic self-help skills (e.g. eating, dressing, personal hygiene), homemaking skills (e.g. elementary food preparation, housekeeping) and socialization skills. Some of the life skills are measured by the BCP, such as self-help skills (strands 1-10), eating skills and basic socialization skills (strands 23-31). Components of a complete life skills building program can be found throughout TDMHMR facilities, but no one school has a full range of housing, homemaking, or socialization programs.

3. Programs to increase educational skills for learning also follow developmental sequences ranging from basic processing (e.g. perceiving, labeling responding) to communication skills (e.g. language, reading, academic skills). The levels of early development assessed by the BCP include perceptual-motor skills (strands 11-17), language skills (strands 18-22) and academic skills (strands 32-39).

The educational process of training is at least as important as the training programs. A sincere caring for the mentally retarded was very evident in most of the employees and this caring is an essential ingredient in helping the retarded, but is not sufficient. It is no substitute for teaching skills. The teaching staff appeared to have a good grasp of some of the following:

a. knowledge of the retarded and the developmental aspects of learning;

b. knowledge of the processes involved in learning (Wawrykow, 1975) -- perceptual and exploratory processes, associational and integrational processes, and expressive-verbal and motor processes;

c. knowledge of the interaction of the learning processes at the various developmental stages;

d. knowledge and skill in facilitation of learning at a particular stage of development;

e. the interpersonal skills and behavioral skills with which to facilitate learning and to help the learners acquire motivation and skill for self-initiated learning;

f. knowledge of and skill in facilitation of the elderly mentally retarded with dignity and respect.

4. Programs to enhance vocational skills for working are conducted in activity centers and sheltered workshops. Mentally retarded persons of lower ABL are acquiring work skills. There is limited opportunity for graduates from these programs to be placed in gainful employment, although many become at least partially self supporting.

E. There has been a trend to bring vocational habilitation services to the community. While initially the TDMHMR activity centers and sheltered workshops were on the state institution campus as often as off campus, the recent trend has been toward placing these facilities off campus. The centers are usually operated jointly by the rehabilitation commission, by community mental health and retardation centers and by state schools.

Although many residents find the vocational program rewarding, the training does stop short of normalization, leaving some clients with a feeling of discomfort that could be expressed:

"Gosh, I still come to this special place. I'm not going ahead. Maybe I can't. Others go to work in a warehouse or factory. I want to be like them, but I can't, I can't succeed."

To be sure, not all feel this way. It does seem reasonable to continue working with each resident, step by step to get him to the point where he can maximize his normalization. An alternative to the above might be:

Entry - No Skills - Poor Self-Concept

Human Skills For Living — Educational Skills For Learning — Vocational Skills For Working

Activities Center

Sheltered Workshop

1. Training for a specific job

   ...under the supervision of a master trainer, educated by TDMHMR.

   ...appropriate for the developmental level (ABL, age) partially completed in the workshop and terminating in the factory.

2. Placement in the same job in the factory still under the guidance of the master trainer who functions as company supervisor.

F. Many more residents were placed in the community during FY 1975 than for each of the preceding years. Two particular problems have arisen because of this influx of mentally retarded persons into the community:

   1. Lack of continuity of service from the institution to the community center staff.

      Communication between institution and community services should be encouraged. One possibility might be a conference before discharge between the institutional staff, local staff, the mentally retarded person and his family. In the absence of a meeting, other avenues for dealing with this "long distance" problem need to be devised (perhaps use of a conference telephone call).

   2. Lack of community living alternatives resulting in overuse of nursing homes.

The range of community living alternatives which are needed include:

1. Full Time Resident

Institutionalization

State School

State Hospital

Private Institution

2. Part Time Resident

State School
State Hospital
Private Institution

Day Care or
Night Care Only

On-Campus Quarter Way
House

Off-Campus Quarter Way
House

3. Full Time Halfway House

i.e. Lowry or Razer Hall (Denton)

i.e. Lubbock and Amarillo Group
Homes with House Parents,
Houseparent and Professional
Directed Supervision

4. Full Time Three Quarter Way

i.e. Boarding Home
i.e. Foster Home
i.e. Apartment Grouping
Examples include HUD developments
in El Paso and Brenham, and private
projects in Lubbock and Amarillo

Minimal Supervision by House Parents
or Professionals. Primarily Consultative or Non-Directive

INCREASE IN INDEPENDENCE AND ACCEPTANCE OF RESPONSIBILITY FOR SELF

5. Independence

Normalized Community Living

i.e. Apartment by self or with one
or two others

i.e. Home by self or with one or
two others

No Supervision. Minimal Non-Directive Consultation

While examples of a range of living alternatives are available in most communities, at present no one community was found to offer the full range.

G. Normalized living requires that nursing and medical care be available. Alternative care facilities currently in operation must provide this care. The ICF-MR standards requirements have helped establish a high level of care. However, the current ICF-MR facility standards must be questioned for use with the more normalized mentally retarded. Is this the most cost effective means of community placement? Are the standards set up to reasonably meet the needs of the mentally retarded population? Are there too many nursing and medical requirements. Research is needed.

H. Many questions have been raised by this investigation and point out the need for further research.

   1. What are the developmental concomitants of mental retardation:

      a. Which demographic, environmental, and program variables maximize growth and happiness at each stage.

      b. What are the biodynamics and neurodynamics of aging in persons whose retardation is caused by genetic or environmental factors, or a combination of both.

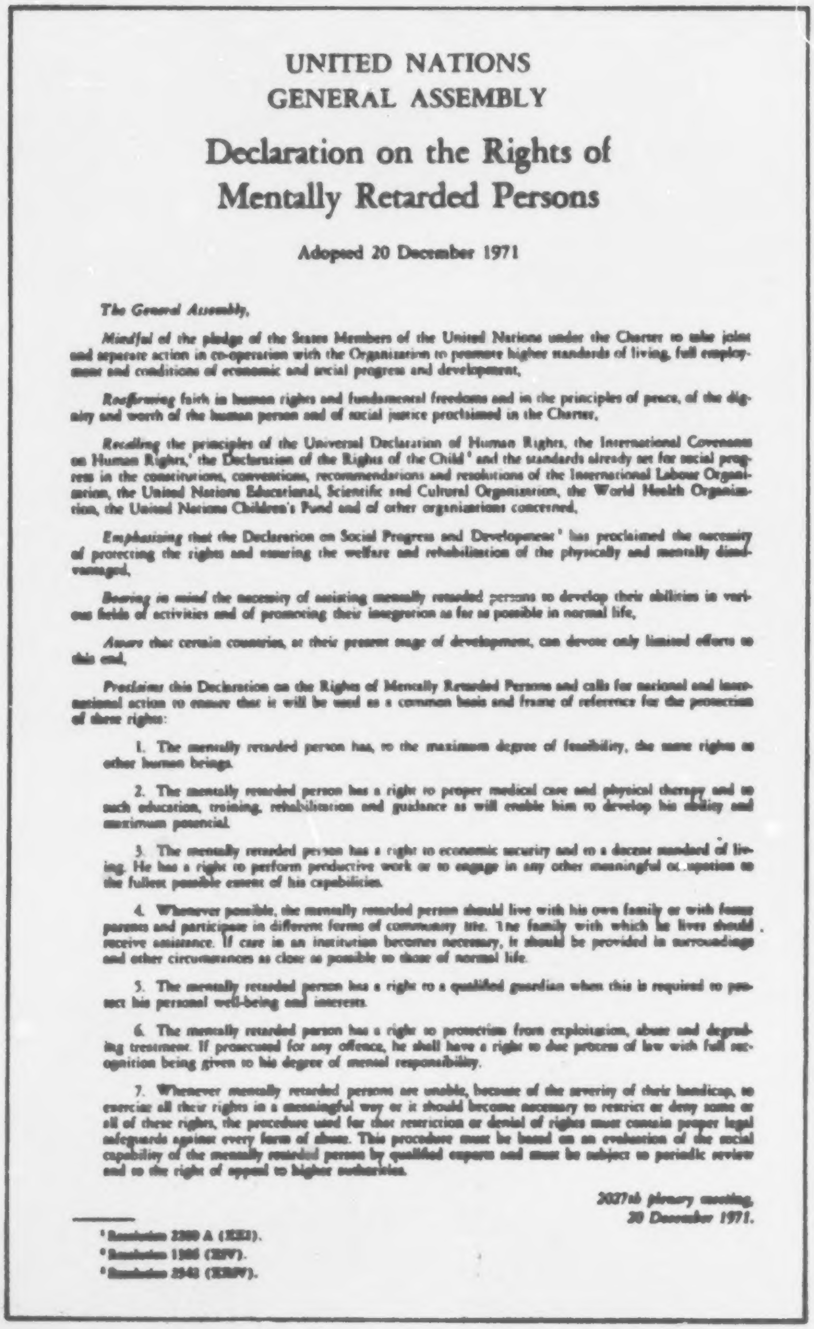
      c. Is the developmental sequence in affective, behavioral and cognitive domains the same for retarded persons as for the general population.

2. What is normalized vocational development for retarded persons at each developmental stage?
    a. Should contracts suited to the developmental stage of the retarded person be sought that enable job placement of the mentally retarded in the company factory or assembly plant under a master trainer paid by TDMHMR?
    b. Do we care enough or have we adequate skills and resources to implement adequate programming? Can most retarded persons age 35 or older acquire the skills necessary to make job placement succeed? Can we afford to do this? Can we afford not to do the above?
3. Is the concept of a retirement home at San Angelo adequate program procedure compared with community placement considering the present level of community resources.

APPENDIX I

Declaration on the Rights of Mentally Retarded Persons

United Nations
General Assembly
December, 1971



UNITED NATIONS
GENERAL ASSEMBLY

Declaration on the Rights of Mentally Retarded Persons

Adopted 20 December 1971

The General Assembly,

Mindful of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights,[1] the Declaration of the Rights of the Child[2] and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and of other organizations concerned,

Emphasizing that the Declaration on Social Progress and Development[3] has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

2027th plenary meeting,
20 December 1971.

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[1] Resolution 2200 A (XXI).

[2] Resolution 1386 (XIV).

[3] Resolution 2542 (XXIV).

APPENDIX J

Goals, Objectives, and Recommendations

Report to the President

Mental Retardation Century of Decision

Henry V. Cobb
Series Coordinator

Raymond Nathan
Editor

David Mathews
Chairman

N. Lorraine Beebe
Vice Chairperson

President's Committee on
Mental Retardation

APPENDIX J

Goals, Objectives, and Recommendations

In the preceding chapters, the President's Committee on Mental Retardation has stated goals, objectives, and recommendations in the context of the situation they are designed to meet. For each, a rationale is presented.

Readers, however busy, are urged to look at the recommendations first in that complete form. The listing that follows then can serve as a handy reference.

Chapter 3—Full Citizenship and Legal Rights

Goal:

The attainment of citizenship status, in law and in fact, for all mentally retarded individuals in the United States, exercised to the fullest degree possible under the conditions of disability.

Objective I: ***The assurance of maximum freedom to exercise legal and constitutional rights and responsibilities.***

Recommendations:

A duly selected body, working in concert with public and private agencies, should *develop at an early date a legislative guide and information-sharing system*, to be used by the States to develop statutes to protect the constitutional rights and facilitate full citizenship of mentally retarded and other handicapped persons.

All States that have not already done so should institute a careful review and revision of their statutes and legal practices relating to mentally retarded and other handicapped persons, to ensure conformity with constitutional guarantees of equal rights, due process and equal protection of the laws.

A nation-wide system of "public" legal advocacy services specializing in the protection of rights should be available to mentally retarded and otherwise handicapped persons. Branches of this system should be established in all States.

Offices of special appeal, with final recourse to the courts, should be available in each State to protect the rights of the retarded and other handicapped individuals, as well as those of others. The offices should be established as commissions or public corporations separated from the regular governmental systems, with authority to act independently on behalf of handicapped citizens.

Statutes and court procedures bearing on competency should be clarified and revised a) to recognize gradations of competence, b) to recognize that areas of competency may be quite varied and therefore should be separable in law, c) to assure full and explicit due process safeguards on any and all areas of competency, and that the scope of any judgment of incompetence is made fully explicit, and d) to ensure that restrictions of competency be limited to a specific period of time or subject to periodic review.

The LEAA program of the Department of Justice should concern itself with a variety of matters affecting mentally retarded persons in both the civil and criminal justice systems. These would include the clarification of procedural matters; pre-service and in-service training of lawyers and law enforcement, court, juvenile justice, and criminal justice personnel in the nature of retardation, the legal and constitutional rights of handicapped persons, and procedures relating to retarded individuals; and the provision of funds for research and study of these matters.

All professional persons who work with mentally retarded individuals should be trained to recognize issues of human right, including but going beyond legal issues.

Educators, social workers, and other counselors should be trained to impart to mentally retarded persons an understanding of their rights and concomitant responsibilities in a more open society.

Establishment of programs 1) to prevent delinquency in retarded persons at risk, 2) *to divert the handling* of retarded offenders from the regular criminal courts to other procedures, and 3) *to provide corrective rehabilitation* of retarded juvenile and adult offenders.

Every effort should be made to consider and *resolve issues in regard to maintenance of and access to records* of handicapped and other persons. The issues revolve around the rights of privacy, personal access, confidentiality of communications, "need to know," and appear to involve issues of conflict of rights.

Objective II: *The assurance of maximum independence of retarded citizens.*

Recommendations:

The development of a compendium handbook, subject to annual revision, codifying statutory provisions of the States and Federal Government concerning

- Legal status, competency adjudication, and guardianship (both of person and property) for mentally retarded persons.
- Protective, developmental, and supportive services for mentally retarded persons.

Development by progressive steps of a system which will guarantee *fully adequate economic security and independence* to all people, including mentally retarded individuals. Such a system should begin with current Federal and State programs and develop over time the following provisions:

- A guaranteed minimum income adequate to meet the normal costs of daily living.
- A credit or voucher system, vested in the individual retarded consumer in need, whereby retarded individuals could acquire necessary special services from a choice of accredited providers. (See Humane Services, Chapter 6, Objective I.) Nothing in these recommendations exempts service—providing agencies from the application of eligibility standards or from accountability in expenditures as provided by law.

In any modifications of economic security statutes, HEW and the States should *provide by law and regulation, for the recognized privilege of any certified personal representatives,* selected by, or under contract to, a mentally retarded person or his legal guardian, to serve as his agent and to negotiate for services in his behalf.

The Federal Government should provide *financial assistance to the States to cover costs of transition* of individuals from institutional to community services, and costs of transforming or replacing central institutions for more functional purposes consistent with the needs of retarded citizens.

A public corporation or commission should be established in each State to provide guardianship services, including the certification of persons qualified to serve as personal representative agents. (See Chapter 6, Humane Services, Objective III.)

Legislation should be developed by the Congress and the States to *authorize and fund adequate systems of humane services* to develop, support, and protect the rights of retarded persons as citizens. (The content and structure of such services are set forth in Chapter 1 and in Chapter 6, Humane Services.)

Objective III: *The assurance of maximum access to a free and open community.*

Recommendations:

Institutional commitment, non-voluntary or voluntary, should be prohibited by law except through due process procedures establishing that it is required to prevent the person from doing harm to himself or others, that it is the least restrictive solution available, that the period of commitment is specifically limited and subject to court review, and that the subject is represented by counsel at commitment hearings.

Public laws should be established and enforced requiring the use of positively assisting *devices to enhance the freedom of movement and safety* of the *mentally and physically handicapped* in all public buildings, transportation systems, public ways, and publicly financed housing.

State laws and local ordinances should protect the right of handicapped persons to *appropriate residential arrangements*, free of discriminatory zoning regulations, inappropriate licensing standards and codes.

Chapter 4 Prevention: The Right To Be Well Born

Goal:

Reduction of the incidence of mental retardation from biomedical causes by at least 50 percent by the year 2000.

Objective I: ***Full commitment of the people of the United States to the prevention of mental retardation from causes operative in reproduction and prenatal development.***

Recommendations:

A national education effort supporting planned pregnancies, which emphasizes optimal conception and maternal health, will be the most effective means to reduce incidence of mental retardation. This effort will ensure the early use of known ways of avoiding the occurrence of mental retardation.

Genetic diagnostic and counseling services are needed by high-risk persons. Outreach genetic services must be extended from university and medical settings to more people in need, especially those in rural settings and in vulnerable population groups.

Couples should be encouraged to take due account of what is known about the *timing of pregnancies* in terms of maternal and paternal age, and to have their children during the optimal reproductive age.

Couples should avail themselves of all knowledge that will improve the probability of bearing normal children. The *discussion with one's physician of any factor in family history bearing on mental or physical problems* may aid in identifying couples at risk for mental retardation. This may be followed where needed by genetic counseling or application of preventive techniques which can reduce disabilities from inherited factors and allow the birth of normal children.

Objective II: ***A health delivery system is needed which assures equal access to quality care at reasonable cost.***

Recommendations:

Comprehensive maternal and child health care services must be available and accessible to all women and their children, including those families with low income and those residing in rural areas.

Exposure of pregnant women to radiant energy sources, infectious agents, dangerous drugs, and other known and suspected hazards should be minimized until research has clarified the extent of danger these influences pose for the developing fetus.

Malnutrition, which is a contributing factor to prematurity, low birth weight, and neurological abnormalities, should be decreased by all means available, including public education on known nutritional hazards, accurate consumer information on nutritional values of processed foods, and by selective supplementary diet for high-risk pregnant and lactating women and their children.

Routine periodic developmental assessment of all preschool children from birth should become a normal and accepted part of child-rearing practices in order to detect and treat incipient developmental problems at an early stage.

Programs for prevention and treatment of child abuse are necessary to reduce risk of brain damage. Physical abuse of children can cause neurological damage including mental retardation. It should be noted that some children with mental retardation are at an increased risk of being abused.

Persons with mental retardation must be served in all health care systems, both medical and dental, available to the general public.

To reach all persons in need, a *more equitable distribution of health manpower and resources* must be developed. Medical, communications, and transportation technologies must be more broadly exploited.

An interim system of cooperative funding can provide the needed preventive and ameliorative health care during the next decade. Intensive study of its operation can lead to development of subsequent funding systems during the balance of the century.

More rigorous identification and eradication of toxic substances in the environment, such as lead paint, airborne lead, waterborne mercury compounds, and specific organic toxic compounds, should be pursued.

Objective III: *Continued advancement of knowledge through research.*

Recommendations:

Advancement of basic information in reproductive biology is needed in order to understand and to ensure normal fertilization and gestation, and to reduce incidence of genetic error.

A broader understanding of fetal development will offer options for diagnosis and treatment in the prenatal period.

Research is needed to improve contraceptive alternatives to reduce unwanted pregnancy and allow optimal planning of reproduction.

New approaches and techniques are needed for *improved research analysis* of such complex medical/social problems as nutrition, child abuse, drug abuse, and environmental hazards, and their effect on incidence of mental retardation.

Research methods are needed to explore child growth and development following maternal disease during gestation, obstetrical complications, prematurity, and prolonged respiratory support. Continued fetal research is needed to assess the impact of environmental agents which may have toxic effects, or produce congenital deformity or genetic mutation.

The effects of maternal drug use and drug abuse on the fetus require research.

Emphasis should be given to those *goal-oriented research programs* that address identified problems and produce the most cost-effective prevention of mental retardation, but not at the expense of broad basic research.

A major effort is needed to bring together separate research findings systematically for more effective compilation, technical implementation and application to prevention.

An effective information center should be established at the national level to identify and monitor current research related to prevention of mental retardation in order to improve the flow of information and its application in service delivery.

A coalition to include private, public, and consumer groups is needed to gain broad support for biomedical, behavioral, and environmental research designed to prevent or ameliorate mental retardation.

Public education must be developed to create understanding of the benefits to be derived from basic biomedical, behaviorial, and environmental research.

Research and demonstration programs are needed to further develop effective strategies for facilitating advancement of young developmentally delayed *and mentally retarded children.* Such programs must be field-tested on a broad scale before being implemented on a massive basis.

Objective IV: *A total campaign of public education on the known means of preventing mental retardation must be developed.*

Recommendations:

School curricula at all appropriate levels should include information on the following subjects related to parenthood:

Human reproduction;
Growth and development of children;
Importance of the parent-child relationship in the social, emotional, and cognitive development of the child;
Hazards of some modern life-styles to the birth of normal children.

Education for health-related careers should include training in the following areas:

Consumer participation and social problems;
Inter-disciplinary team collaboration in patient care;
Administration of multi-disciplinary service programs;
Preventive and public health aspects of all health specialities in relation to problems of mental retardation and developmental disability.

Various chemicals, some medications, and excessive amounts of alcohol and nicotine during pregnancy can increase the risk of having a mentally retarded child. *Women should be impressed with the importance of seeking their physician's advice* before using any such products when planning pregnancy.

The public should be informed that chemical and other environmental pollutants exert unknown but potentially hazardous effects on the developing fetus. Such awareness should provide added impetus to the necessary research and enforced controls of environmental hazards.

Obtaining medical care early during pregnancy ensures the best opportunity to monitor both the mother's and the baby's health. The importance of such early care should be brought before the widest possible public.

Chapter 5 Prevention: The Right to a Good Start in Life

Goal:

To reduce the incidence and prevalence of mental retardation associated with social disadvantage to the lowest level possible by the end of this century.

Objective I: *Elimination of prejudicial attitudes and discriminatory practices based on race, ethnic membership ("racism") or social class as a root source of impaired or retarded human development.*

Recommendations:

The President of the United States, the Congress, and the Courts must exercise continued leadership in the *elimination of attitudes and practices that create disadvantage* to minority persons in achieving their potential human development.

Affirmative action in compliance with statutory requirements must be vigorously implemented to *assure that minority and disadvantaged individuals will be appointed* to boards, commissions, and administrative positions with decision-making responsibility on matters affecting the developmental opportunity of all persons in need.

The selection of personnel in all departments to administer Federal and State programs designed to meet the needs of poor and minority group persons must include consideration of appropriate experience, training, and sensitivity to the special problems, attitudes and value systems reflecting ethnic and economic differences.

Community Action Programs should be continued and funded on a national level with emphasis on greater involvement of poor and minority persons in decision-making and on the creation of a climate of self-esteem and personal worth conducive to personality growth and mental development.

Objective II: *Improvement of home and community environment and living experience through a persistent attack on conditions which impede or distort full development of human potential among poor and minority groups.*

Recommendations:

The national Home Start program to assist low-income parents in the early developmental training of their children in their own homes should be developed systematically as knowledge and experience expand. This effort should use the best means available to stimulate the cognitive development of children through parent-child and other social interactions, with due respect for cultural differences.

Continued and sustained research at basic and applied levels must be supported by appropriate Federal agencies to develop knowledge and implement the best means of early assistance to families and children at risk from psychological and social hazards.

The total home and community environment must be improved for minority, poor, and otherwise deprived people in areas such as housing, health services, recreation, employment, and nutrition.

The current welfare system should be revised to provide for the training and utilization of *welfare service workers indigenous to the neighborhoods* to which they are assigned. Based on intimate knowledge of their constituencies, such workers would provide welfare recipients a basic consumer education relating to purchase and preparation of food for adequate nutrition, making and buying clothing, purchase of needed services, and other aspects of home and family management.

Access to child development centers for poor and minority group children should be on an equal basis with all families in need of such service. This would be supplemental to home-centered training programs recommended above. Such centers should be strategically designed and located to serve both urban and rural communities.

Monetary aid must be provided to low-income parents for education and employment training as a means of improving the economic and psychological life of the family.

More direct health services to needy families should be provided on a progressively improving basis. Such services should stress preventive and ameliorative measures of all kinds relating to hazards to child development and mental functioning.

Objective III: *Equal educational opportunity for all persons, encouraging cultural differences without penalizing and damaging development.*

Recommendations:

Methods and procedures must be improved for determining the educational needs of individual children exhibiting problems in school. Labeling and assigning children to classes for the mentally retarded by cursory procedures employing inappropriate tests is discriminatory and unjustified, especially when applied to children from cultures other than those on which tests have been standardized.

In support of the previous recommendation, *broad programs of educational research and development* should be Federally funded over the next 25 years to discover and develop the best approaches to equitable individualized education for all children, including the development of improved, culturally sensitive assessment methods.

Curricula for certification of teachers, administrators, and other educational personnel should include courses focusing on both the positive and negative impact of racial, ethnic, and economic factors on human development.

Teachers working with children who are in any way disadvantaged should be specially trained and qualified and should receive commensurate salary and advancement incentives. This is designed to eliminate the still-persisting tendency in some school systems to assign inferior or incompetent teachers to work with disadvantaged, handicapped, or behaviorally different children, and to practice other forms of covert discrimination which have the effect of increasing rather than reducing disadvantage.

Higher education institutions should develop outreach programs of continuing education and field-based programs of training associated with community service settings. A major focus of these programs should be on upgrading the quality of life of poor and minority groups, and on the prevention of environmentally related retardation.

Minority institutions of higher education are uniquely qualified to deal with problems experienced in minority and poverty settings; therefore, Federal funding activity should take advantage of this expertise and ensure that it is utilized to the greatest possible extent. Minority colleges serving primarily the disadvantaged must receive an equitable share of State and Federal funding. Present statutory provisions requiring equitable funding and affirmative action on personnel practices must be positively implemented.

Objective IV: ***Provide adequate controls on the allocation and use of public funds, to safeguard the interests of the populations most at risk from social and economic disadvantage.***

Recommendations:

The Federal Government must assure, within the language of enabling legislation or by *clear designation of legislative intent, how funds are to be allocated* and spent in programs for poor, minority, and handicapped persons, and require demonstration of compliance.

Legislation for health, education, and welfare programs must ensure *proper monitoring and accountability* of programs for people who are mentally retarded, based on outcome criteria in the lives of those served.

Chapter 6 Humane Service Systems

Goal:

Adequate and humane service systems for all retarded persons in need of them.

Objective I: *A comprehensive array of service resources available to meet the essential needs of all retarded persons in all sections of the United States.*

Recommendations:

A minimum array of essential developmental, supportive, and protective services must be guaranteed to mentally retarded persons by Federal action in collaboration with the States, as a first order of priority. Services beyond such minimum levels must be developed and supported on a timely schedule.

Services must be equitable and delivered according to need; provided through public, voluntary or purchase sources, with emphasis on access by choice; delivered by competent manpower selected for its trained capacity to meet service objectives; focused on helping retarded persons achieve the highest possible levels of personal and economic independence.

Interdepartmental policies at Federal and State levels should emphasize *coordinated, simplified, and unified procedures for application and eligibility determination,* so that mentally retarded consumers can get the services they need.

Objective II: *The exercise of free choice and decision by every retarded person or his personal representative in matters that concern his interests.*

Recommendations:

No major decision should be made on behalf of a mentally retarded person except by himself, or by an agent whom he or a duly constituted authority designates to speak for him; this principle must be established by law, regulation, and judicial initiative, and should be assured by HEW, the Department of Justice, and the States.

Administrative procedures of service agencies must reflect the right of the mentally retarded person or his personal representative to select freely any service of his choice for which he is eligible and to express need and demand for those services which his disability requires. This includes the right to coordinate such services for his own unique purposes and to change service agencies at will, as other people normally do. To this end, all Federal agencies and the States should officially recognize this principle through policies, regulations, and affirmative action.

The exercise of meaningful choice or decision requires a basis of *informed participation and consent*. Consequently, all Federal agencies and the States must provide suitable means of guaranteeing mutual understanding on any matter requiring choice and decision affecting a mentally retarded person.

Objective III: *The availability of a personal representative for every mentally retarded person who wishes or requires one.*

Recommendations:

Public policy must assure to every mentally retarded person or his legal guardian opportunity and means to select or employ an agent or agency as his personal representative, to negotiate on his behalf for any available service he requires, no matter how brief or extended his need for service may be. Such policy should be embodied in law and regulation, and must provide for funds or credits to assure to each retarded person the means of free selection of such an agent. The agent or agency selected as a personal representative must be completely independent of any serving agency or system, except that recognition and qualifications for such representative should be established by law.

In order to *stimulate the supply of persons qualified to give competent representation as service brokers to mentally retarded clients*, and to protect against exploitation by unqualified agents, HEW and the States should provide by statute and support for the recruitment, training, and certification of persons with the knowledge and skill necessary to perform this function.

Objective IV: *Maximum opportunity for every mentally retarded person to live in a local community setting of his choosing.*

Recommendations:

Using available legislation, the Federal Government and the States must develop long-range programs so coordinated as to *assure mentally retarded persons an increasing range of choices as to where they shall live*. The choices may vary from independent living to fully protected care, and should be responsive to consumer demand. (See Role of Government, Chapter 9.)

Coordinated with residential alternatives in the local community, there must be developed appropriate, adequate *services essential to help retarded persons remain in homes of their own choice*, including living with their own families, with friends or by themselves.

Restrictive building and safety codes and zoning ordinances must be modified to recognize the degrees of independence and responsibility of retarded persons living in the community.

Central, comprehensive, publicly supported institutions for mentally retarded persons must undergo an orderly process of change from their traditional role as long-term, all-purpose, high-capacity and self-contained organizations to that of care and treatment facilities for specific purposes, with capacity governed by purpose.

States and communities should utilize technical assistance, such as environmental consultant services, involving functional designing principles and flexible design models, for both community and central residential settings for the mentally retarded.

Comprehensive review and continued research should be conducted on the effects of all types of residential service on the development of retarded persons with varying impairments.

Objective V: ***Maintenance by all serving agencies of standards of quality and accountability acceptable to the community and to the individual mentally retarded persons being served.***

Recommendations:

A basic code of uniform standards of service for mentally retarded persons should be adopted by Federal departments serving mentally retarded persons, and by the States. The code should consist of fundamental principles directed toward service outcomes, rather than specific and detailed procedures. Substantial observance of these standards must represent a condition for any public financial support for delivery of such services. Waivers should be granted only on specific justification provided by law and regulation. There must be legal, administrative and budgetary provision for enforcement of these standards, and reasonable but limited time for existing facilities to demonstrate compliance.

A workable system for the reporting, storing, codifying, analysis, evaluation and dissemination of *information on service delivery* to mentally retarded persons must be designed and put into operation at the earliest possible time. The resulting information should be disseminated in summary form to the public at large, and regularly updated.

In order to effect quality control, Federal departments serving mentally retarded persons should put into effect a *financial reward and penalty system* applicable to all formula and discretionary grant funds to the States. This system should be responsive to proven ability or failure to provide needed services, maintain quality standards or meet reporting obligations. The system should be based on small but significant increments or decrements in financial support for achievements of or failure to meet obligations.

Every Federal, State, and local program serving mentally retarded persons should be required to make regular evaluations and issue public reports on the *outcomes of service* in relation to financial or social costs. The findings should be based on appraisal of services made by mentally retarded consumers or their personal representatives, by the serving agencies, and by independent judges or evaluating agencies.

Objective VI: ***Adequate research maintenance and utilization and manpower development to implement the most effective service delivery possible.***

Recommendations:

Development of a *national study and reference center* on mental retardation and related matters. This center would serve two primary purposes: (a) as a focus of continuous study of the large-scale issues of principle and policy, linking all aspects of the problem toward the achievement of national goals; and (b) as a forum for the continuing intercommunication of all organizations, agencies, groups, and individuals in any way connected with the prevention of retardation or the delivery of services to mentally retarded citizens. Such an organization would be private, non-profit, and independent of unilateral control by any of the specialized groups it might involve.

Active and continuing consolidation, field testing, coordination and *transfer of research findings* on mental retardation to serving agencies and systems, training institutions, and other research centers should be systematically developed. This system should provide, through HEW, regional offices, and other channels, continuing technical assistance to State and local serving agencies and training centers to assure the translation of new knowledge into manpower preparation, pilot service innovations, and long-range service development.

The planning of manpower needs and development should be addressed immediately by HEW in collaboration with the States. Such a plan should (1) develop the means for long-range determination of manpower requirements under the existing state of the art of service delivery; (2) develop and promulgate long-range manpower development plans for the nation, including provision for new types of manpower as projected programs and future needs determine them; (3) provide for regular modification of these plans to incorporate new knowledge and technical developments; and (4) assure an adequate present and future supply of trained serving agents to meet requirements of adequate and humane serving systems.

In order to carry out the necessary training and preparation of manpower to meet the needs in all parts of the country, HEW should develop a comprehensive program involving the full resources of higher education. *Such a program should be designed to provide adequate manpower development* to meet all the needs of mental retardation in each part of the United States on a long-range basis. It should use all feasible means of developing and utilizing the training resources in the educational institutions of each State and area through consortia, out-reach programs, in-service extensions or other means, in addition to traditional academic degree programs. Universities, public and private colleges, community and junior colleges should all be involved in these efforts, with the role of leadership and coordination designated on a basis appropriate to the characteristics and resources of each area. The scope of manpower concerns falling within this program would be limited only by relevance to the issue of mental retardation and related disabilities. It would range from workshops for the orientation and training of volunteer personnel, through the training of direct care personnel, to professional training of the most advanced nature for administration, research, teaching, and professional service functions.

A significantly expanded effort should be made to *involve large numbers of volunteers* in many areas of service delivery. Volunteers should be recruited particularly among those portions of the population outside the work force, such as older Americans who can be expected to increase in numbers significantly in the next quarter-century. Volunteer services can be developed both to complement and to supplement professional services.

Chapter 7 **International Relations**

Goal:

The attainment of a high and stable level of international relations in the cooperative resolution of the universal human problems of preventing and ameliorating mental retardation.

Objective I: ***Full and continued participation of United States governmental and non-governmental agencies and organizations in international bodies concerned with mental retardation.***

Recommendations:

Many United Nations agencies conduct activities relating to mental retardation, and the UN General Assembly itself adopted a Declaration of Rights of the Mentally Handicapped in 1971, with United States support. The United States, under State Department leadership, should participate actively in furthering such efforts.

The Department of State and other agencies of Government should maintain active interest and participation in the *Inter-American Children's Institute* of the Organization of American States, and support the involvement of U.S. citizens and groups in the activities of this organization related to mental retardation.

The Department of State, HEW, PCMR, and other agencies of government should encourage and support membership and participation of United States citizens and groups in such *non-governmental organizations* as the International League of Societies for the Mentally Handicapped and the International Association for the Scientific Study of Mental Deficiency.

Objective II: ***International assistance programs in mental retardation, designed to utilize the developed resources of any country in the organization and operation of mental retardation programs, techniques and personnel training in other countries.***

Recommendations:

The activities of *UN agencies* as the intermediaries for requested assistance.

The *AID programs* of the United States.

Such programs as *"Partners of the Americas"* PREP program, involving relationships between North American universities and those of Latin America; and other relationships fostered by the Organization of American States.

The use of blocks of *Fulbright-Hays Grants* focused on the field of mental retardation.

Short-term intensive *workshops for personal training.*

Short-term intensive *workshops on organizational and operational techniques* in mental retardation programs.

International *exchange of films*, film-strips, and slides with appropriately translated or subtitled explanatory text.

The continued use of *PL-480 counterpart funds* as authorized by Congress on mental retardation projects by agencies of HEW.

Objective III: ***Development and maintenance as basic policy of the United States of the international exchange of knowledge and information on all aspects of mental retardation.***

Recommendations:

Participate in the conduct and the reporting of *international scientific seminars* and conferences sponsored by international organizations, universities, scientific and professional associations, and the like.

Encourage and support the *exchange of visiting groups* of professionals, students, and citizens for better understanding of programs and facilities for retarded persons in various countries.

Development of systematic means, under the leadership of the Library of Congress, for the *exchange and translation of significant world literature* in the field of mental retardation.

Development of and support for an *international information system* in mental retardation.

The *International Directory* of Mental Retardation Organizations and Activities—published as a joint venture of PCMR and the International League of Societies for the Mentally Handicapped. This needs to be maintained in a current state by periodic revision.

Facilitation by the Department of State, in cooperation with HEW, PCMR, and other government agencies and professional organizations, of international research projects and seminars on significant problems in mental retardation, with the provision of *supporting funds for organization and travel.*

Chapter 8 **Public Attitudes**

Goal:

To achieve a firm and deep public acceptance of mentally retarded persons as members in common of the social community and as citizens in their own right.

Objective I: ***Advancement of those values which emphasize the worth of every human being without regard to his material possessions, his job status, his productivity, his IQ, or his beauty, and which recognize the importance of diversity and the right to be different.***

Recommendations:

Appropriate attention must be given to the areas of human values, of working with minority cultures, and of dealing with handicaps in the *training of all new teachers*, plus in-service training and the furnishing of curriculum aids in these areas for all present teachers.

All students during the period of elementary and secondary education should be familiarized with the nature of handicapping conditions, both physical and mental, in the context of human values expected in the teaching environment previously discussed.

Implementation of such a value-oriented approach to human relations in the education of children must apply at all levels;

- The *Federal Government* must continue to move forward under the authority of Part D of the Education of the Handicapped Act, which provides not only for the training of special education personnel, but also for the training of regular teachers in knowledge and sensitivity to the needs of the handicapped.
- The States should make training in human values and working with the handicapped a requirement in the *certification* of all teachers, not only of special education teachers.
- *Schools of Education* should develop units on human values and teaching the handicapped as part of the curriculum for all students.

Courses on mental retardation and related disabilities should be included in the curricula of all students of medicine, dentistry, nursing, law and law enforcement, education, religion, psychology, social work, and any other field in which professional practice involves contact with developmentally impaired persons.

The continuation and expansion of the "*education for parenthood*" program is essential, with inclusion of material on mental retardation.

Civic organizations in each community should search for creative ways to *enhance community regard* for the teachers, social workers, recreation leaders, employment counselors, residential aides, and all others who provide supportive service to retarded persons.

ACTION, the National Center for Voluntary Action, and corresponding groups in every community should *intensify the enrollment of volunteers* in activities involving direct contact with retarded persons. In some cases, monetary incentives at least to cover expenses should be used to compensate, as in the Foster Grandparents program; in others, tax credits; and in still others, academic credit in field assignments.

Objective II: *A pervasive feeling of confidence that there will be a sufficiency of jobs, energy and other material goods to support a realistic surge toward humanized values. In that atmosphere, retarded and other handicapped persons will be regarded not as usurping competitors or as a burden or threat, but as needed participants in society, in the work force and in other community activity.*

Recommendation:

Advocates for those who are retarded must *cooperate vigorously in national and local efforts to achieve a society of sufficiency*, and work for a climate of public confidence that such a society is on the way.

Objective III: *Use of changing trends and techniques in communications to promote (a) greater understanding of and appreciation for handicapped persons as neighbors, fellow students, fellow employees, and fellow citizens, and (b) understanding of the means of reducing the occurrence of mental retardation and other handicapping conditions.*

Recommendations:

A continuing program, substantial in size and high in quality, for *educating the general public via all communications media toward acceptance* of retarded and other handicapped persons must be sustained.

A continuing program, substantial in size and high in quality, for *educating the public concerning the causes and means of prevention* of mental retardation is essential.

Every agency or organization concerned with mentally retarded people—national, State or local, public or private—must intensify its own informational efforts and *build a community understanding component into every operating program.*

Chapter 9 The Role Of Government

Goal:

Equitable, coordinated, efficient and effective use of public resources in all mental retardation programs.

Objective I: ***Coordinated and comprehensive planning of Federal, State, and local efforts in the area of mental retardation.***

Recommendations:

The Federal Government should establish a continuing interdepartmental planning system on mental retardation, responsible for the preparation and promulgation of short-term and long-range plans. These plans should be based on joint assessment of needs and resources and the commitment of the participating departments to fulfill their respective responsibilities under the plans.

State governments should establish comparable interdepartmental planning systems at the Governors' level, with similar responsibilities for the preparation and execution of plans for mental retardation programs among appropriate State agencies.

The Federal, State, and local governments should guarantee to all programs in mental retardation, whose effectiveness in relation to planned objectives would require an extended period of operation, *assured fiscal resources for the entire period of the planned effort.*

The Federal Government should create a *national information system* on mental retardation through which its departments and the States may get prompt and reliable intelligence on which to base their planning efforts.

Federal, State, and local planning should enlist *consumer panels,* representing mentally retarded individuals themselves as well as their families and other representatives. These panels should be invited to participate in planning activities so as to assure that planning correctly reflects the interests of those persons for whom it is undertaken.

Objective II: ***Assure, through Federal, State, and local organization and leadership, that program activities involving joint participation of two or more agencies serving mentally retarded persons will be planned and conducted in a coordinated and collaborative way.***

Recommendations:

There should be established in each major department which provides services in relation to mental retardation, the position of an *advocate, responsible to advise the department administrator* of problems observed in the coordination of agency program efforts, to initiate efforts to resolve conflicts and effect solutions, and to call attention to program resources and authorities which may not be fully utilized in the best interests of those being served.

Federal departments should, through bilateral or multilateral agreements, develop routine means to *identify and resolve conflicts in policy*, reflected in proposed or enacted law, proposed regulations, and instructional materials, which may result in one program's operations interfering with the realization of benefits from another.

Each major department providing services should provide a *casefinding and access program* to inform all known mentally retarded persons about services to which they are entitled, and guide them to sources of help in a fashion that assures they are actually offered such help.

Objective III: ***Federal, State, and local accountability for the provision of effective services to mentally retarded consumers in an efficient manner and with due regard for the consumer's rights of redress.***

Recommendations:

Federal, State, and local agencies should require of all case services provided or funded with their assistance, including those provided by private agencies, that a *mutual agreement for the service* and the purpose which it is to meet be negotiated with each person served, and that the degree of fulfillment of such agreements form one basis of determining the effectiveness of service. The confidentiality of such records must be safeguarded.

Federal, State, and local agencies responsible for providing or funding services should establish systems for *periodic monitoring* of program achievements and case benefits, and for evaluating them against both program and fiscal standards.

A prompt administrative appeals procedure should be offered by all Federal, State, and local agencies responsible for providing or funding services. If a mentally retarded person or his representative feels that he is not receiving services in accordance with his express need, he should be able to count on an impartial review and on an appropriate and prompt remedy.

APPENDIX K.

NORMALIZATION STUDY

SAN ANGELO

San Angelo Center, being primarily a state school for mentally retarded persons over age 35, offers a unique opportunity for testing the concept of normalization by comparing community vs. institutional placement. As the staff-resident ratio is the lowest of any of the state schools and not up to JCAH standards, the services must be dramatically augmented. At the same time that programs, staff and services are being developed, the relative effectiveness of institutional vs. community placement can be studied.

San Angelo Center has been conceptualized as a retirement home for the mentally retarded. Within the context of the growing number of "senior citizens housing projects," the concept of a retirement home for elderly mentally retarded can be considered normal. In the light of the length of institutionalization of many of the residents, this may be a desirable alternative. On the other hand, many of the persons at San Angelo are ages 35 to 54 (n = 453), many of these are ambulatory and once have vocational skills. It has been demonstrated that older mentally retarded persons can be returned to the community (Bell, Schoenrock and Smith, 1976; McCarver and Craig, 1974) even in the age range 50-72 (Talington and Chiovaro, 1970).

In order to study the relative effectiveness of these alternative living situations, the following design could be utilized:

(a) Of all ambulatory mentally retarded persons at San Angelo, randomly select four groups of 70 persons, two age 35-54 and two age 55 and older, stratified according to age, sex, Adaptive Behavior Level (ABL), ethnicity, and socio-economic level.

(b) Within each age group, involve one half in training for community placement and retain the second group in San Angelo Center placement.

(c) During the first year -- through the cooperative efforts of TDMHMR Central Offices, TRIMS, the Research and Training Center at Texas Tech and the local university -- develop a curriculum for the staff and develop the community living alternatives necessary for implementation.

(d) By the middle of the first year, begin resident training.

(e) By the middle of the second year, begin placements.

(f) Obtain comparative data every 12 months for each of the first three years and at three year intervals thereafter on:

1. living skills and effectiveness of their use.
2. learning skills and effectiveness of their use.
3. vocational skills for working and/or avocational skills for leisure and effectiveness of their use.
4. costs for initial training, and for post training care.
5. comparative regression/progression levels.
6. degree of activity and length of life.

Service, Training and Research: The primary focus of all programs should be to provide humane service to the retarded person. This goal can be achieved through carefully planned training programs in which respect for the worth of the trainee becomes a model for showing respect for the retarded person. Each program should also be planned so that careful evaluation and research will yield interpretable, generalizable results.

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